TRICARE Provider Handbook

Your guide to TRICARE programs, policies, and procedures

TRICARE South

An Important Note About TRICARE Program Changes

The "TRICARE Provider Handbook" will assist you in delivering TRICARE benefits and services. At the time of printing, the information in this handbook is current. It is important to remember that TRICARE policies and benefits are governed by public law. Changes to TRICARE programs are continuous, and new benefits are added regularly as we continue to make TRICARE a better program. For the most recent information, contact Humana Military Healthcare Services, Inc. at 1-800-444-5445 or visit them online at www.humana-military.com. More information regarding TRICARE can also be found online at www.tricare.osd.mil or by visiting your local TRICARE Service Center.

June 2004

Dear Partners in TRICARE,

At Humana Military Healthcare Services Inc., we realize that you are the most important part of our system of care. We want to make it as easy as possible for you to provide covered services to this uniquely deserving segment of our population.

TRICARE benefits are defined by the Department of Defense, and sometimes mandated or modified by congressional action. It is challenging to develop rules and systems that are easy to understand and use. It is sometimes difficult to accommodate changes in standards of care, especially for a program that is nationwide.

Making use of the information that follows is your best guarantee of hassle-free interaction with us as you provide care to our beneficiaries. If we can improve the handbooks, let us know.

We understand that we are in this together. We count on you and your office staff to help us administer this entitlement program. We stand ready to assist you in this task.

Cordially,

Victor A. Diaz, MD

Victor Diaz, MD, MPH, MPA
Chief Medical Officer
Humana Military Healthcare Services, Inc.


NOAA
U.S. PUBLIC HEALTH SERVICE
1798
DEPARTMENT OF THE ARMY
UNITED STATES OF AMERICA
DEPARTMENT OF THE NAVY
UNITED STATES MARINE CORPS
DEPARTMENT OF THE NAVY
UNITED STATES OF AMERICA
DEPARTMENT OF THE AIR FORCE

Using This TRICARE Provider Handbook

The *TRICARE Provider Handbook* has been developed to provide you and your staff with basic, important information about TRICARE while emphasizing key operational aspects of the program and program options. This handbook will assist you in coordinating care for TRICARE beneficiaries. It contains accurate, updated information about specific TRICARE programs, policies, and procedures.

The provider handbook is available electronically on the TRICARE Provider Web site at www.tricare.osd.mil/provider and on the Humana Military Web site at www.humana-military.com. Behavioral health providers request their handbooks from ValueOptions (Humana Military's behavioral health partner) at 1-800-700-8646. Provider newsletters and monthly updates will include information to insert or replace within your Provider Handbook.

Thank you for your service to America's heroes and their families. If you need any assistance, please contact your TRICARE Provider Relations Representative at the TRICARE Service Center nearest you. Or call 1-800-700-8646 if you are a behavioral health provider.

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An introduction to your TRICARE provider contractor, network subcontractors, and vendors

Welcome to TRICARE and the South Region

What Is TRICARE?

TRICARE is the health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE's primary objectives are to optimize the delivery of health care services in the direct care system for all Military Health System (MHS) beneficiaries and attain the highest level of patient satisfaction through the delivery of a world-class health care benefit. TRICARE brings together the health care resources of the Army, Navy, Air Force, and Coast Guard and supplements them with networks of civilian health care professionals to provide timely access and high quality service while maintaining the capability to support military operations.

TRICARE is available worldwide and managed regionally in six separate TRICARE regions—TRICARE North, TRICARE South, TRICARE West, TRICARE Europe, TRICARE Pacific, and TRICARE Latin America/Canada—jointly by the TRICARE Management Activity (TMA) and TRICARE Regional Offices. TMA has partnered with civilian managed care support contractors (MCSCs) in the North, South, and West Regions to assist TRICARE Regional Directors and military treatment facility (MTF) commanders in operating an integrated health care delivery system by combining the resources of the military's direct medical care system and the contractor's health services support to provide health, medical, and administrative support services to eligible beneficiaries.

TRICARE Regions

Your Managed Care Support Contractor

Humana Military Healthcare Services, Inc. (Humana Military) is responsible for administering the TRICARE program for more than 2.7 million TRICARE beneficiaries in the TRICARE South Region. The South Region includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee (except the Fort Campbell area), and a major portion of Texas (except for the extreme southwestern El Paso area).

Humana Military is committed to preserving the integrity, flexibility, and durability of the MHS by offering beneficiaries access to the finest health care services available, thereby contributing to the continued superiority of U.S. combat readiness.

Humana Military's Network Subcontractors and Vendors

ValueOptions, Inc.

ValueOptions, Inc., (ValueOptions) is Humana Military's behavioral health care partner in the TRICARE South Region. ValueOptions is the largest privately held behavioral health managed care company in the nation.

PGBA, LLC

PGBA, LLC (PGBA) is Humana Military's claims processing partner in the TRICARE South Region. PGBA is a fiscal intermediary for the military's TRICARE health benefits program. PGBA is one of the largest subsidiaries of BlueCross BlueShield of South Carolina.

Provider Resources

Many national and regional resources are available if you or your staff has any questions or concerns about TRICARE programs, policies, or procedures, or if you need assistance coordinating care for a TRICARE beneficiary.

TRICARE Web Site Provider Portal www.tricare.osd.mil/provider

A provider portal is available on the TRICARE Web site. It offers national TRICARE information, including links to TRICARE regulatory guidance, policies, and procedures; TRICARE program options and features; and the latest news and events. It is the main resource for anything you need to know about TRICARE.

TRICARE Online www.tricareonline.com

TRICARE Online is a Department of Defense (DoD) Internet portal to interactive health care services and information accessible by all TRICARE beneficiaries. Each MTF has its own page on TRICARE Online, and most MTF providers maintain an individual "Provider" page on the MTF site. Providers are encouraged to include a picture and specific clinical information about themselves on the page. Many have provided educational links from their page to health care information that they want to share with their patients.

Humana Military Web Site www.humana-military.com

The Humana Military Web site, www.humana-military.com, is host to a full array of Web-based services designed to save providers time and money. This provider portal features pages customized for providers, as well as a section customized for primary care managers.

Online Provider Services

Humana Military's online provider services include features designed to reduce the amount of time providers and their office staff members spend communicating with Humana Military via telephone or fax, which normally reduces the total time spent per transaction. These numerous online applications provide options designed to improve cash flow and even increase office productivity.

Online applications include:

- Patient eligibility check
- Online referrals and authorizations

- Diagnosis/Procedure codes lookup
- Claims status check
- Claims submission
- Fee schedules for downloading
- Schedule of upcoming provider seminars
- Provider locator

"PCM Central"

"PCM Central" is a page within the Humana Military Web site built specifically for TRICARE primary care managers (PCMs) and their office staff. This page ensures convenient access to a host of Web-based services designed to support your TRICARE patient management activities, including:

- Patient eligibility check
- Online referrals and authorizations (immediate confirmation available on many)
- TRICARE patient list
- Claims submission
- Claims status inquiry
- Patterns in medical management reports
- HAL—Humana Military's health awareness program

eZ TRICARE Claims—Electronic Submission

A HIPAA-compliant option that gives all providers the option to submit claims electronically through the Internet. Humana Military network providers must file claims electronically and will receive payment sooner than if they filed the same claim on paper, because claims are submitted more efficiently and with fewer errors and omissions. On average, electronic submission enables TRICARE claims to be processed two to three weeks faster than claims filed on paper.

Other benefits include:

- Real-time claim error identification
- Online editing capabilities
- No software to install
- TRICARE claims processed free of charge

eZ TRICARE Claims allows you to upload batches of claims directly from your practice management system. There's no software to install, no data entry, and no cost for your TRICARE claims. eZ TRICARE Claims can accept a variety of claims formats, including National Standard Format (NSF), ASC X12 837, and even a CMS-1500 print file. Coming soon, you also will be able to file your UB-92s with eZ TRICARE Claims.

Getting Started on Humana Military's Web Site

To access Online Provider Services, PCM Central, and eZ TRICARE Claims, providers must register to obtain a User Identification (ID) and Password for the Humana Military Healthcare Services Web site. Simply log on to www.humana-military.com, select "Provider Resources," "Online Provider Services," then click the link called "Sign Up." An online wizard will guide you through the registration process. Once completed, you will receive notification via e-mail within one to two business days that your User ID has been activated.

The *Single Sign On* feature allows you to access data from multiple Provider IDs without requiring you to sign in using separate Provider IDs. The conversion wizard will locate all your existing provider sign-ins and convert them to your one new *Single Sign On* account. You even get to create your own User ID to access all of this user-friendly provider information.

For more information about these online services, or to request a demonstration, you may contact the provider relations representative at your local TRICARE Service Center (TSC).

Humana Military's TRICARE Service Line 1-800-444-5445

Providers can check the status of referral, prior authorization, or admission requests 24 hours a day, seven days a week, and get the information they need with no waiting. Humana Military's TRICARE Service Line offers the most advanced speech-activated technology available, so providers may say all of their answers in response to courteous, pleasant-sounding

prompts. Other services include material requests.

TRICARE Service Centers

TSCs are located throughout the TRICARE South Region and are staffed with Provider Representatives and Beneficiary Service Representatives from Humana Military to assist both beneficiaries and providers. As network providers, you will interact with TSC staff for many health care services or administrative actions. For the most accurate, up-to-date listing of the TSCs in the South Region, please go to Humana Military's Web site at www.humana-military.com or call the Humana Military TRICARE Service Line at 1-800-444-5445.

Other Provider Resources

The chart below provides a complete list of other provider resources, such as claims processing, referrals, prior authorizations, provider relations, and many more.

Resource	Description	Contact Information
Health Care Finders	A non-clinical person who facilitates referrals and other customer service functions of beneficiaries to military and/or civilian health care services	1-800-444-5445
Prior Authorization and Referral Status Check	For immediate status updates on prior authorization and referral requests	www.humana-military.com 1-800-444-5445
Humana Disabilities Coordinator	For the Program for Persons with Disabilities and the Extended Care Health Option	For Florida (except the panhandle), Georgia, and South Carolina: 1-800-447-6072 For Mississippi, Alabama, Tennessee, New Orleans area, and Florida panhandle: 1-888-323-7155 For Arkansas, Louisiana, Oklahoma, and a major portion of Texas: 1-800-447-8808
Claims (PGBA)	For all claims-related questions	1-800-403-3950 TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031
PGBA Provider Data Management	For provider certification issues	1-800-288-2227, ext. 69550 TRICARE South Region Provider Data Mgmt. Dept. P.O. Box 7039 Camden, SC 29020-7039
PGBA Correspondence	To send correspondence, resubmitted claims, and inquiries	TRICARE South Region Customer Service Department P.O. Box 7032 Camden, SC 29020-7032
Electronic Claims Help Desk	To inquire about electronic claims submissions, and for problems relating to electronic claims	1-800-325-5920, Option #2
Electronic Claims Fax Line	To fax supporting documentation for electronic claims	1-803-713-0354
TRICARE For Life Claims	For questions or assistance concerning TRICARE For Life claims	1-866-773-0404, www.tricare4u.com
TRICARE Mail Order Pharmacy Program	For questions concerning the TRICARE Mail Order Pharmacy Program	1-866-DoD-TMOP (1-866-363-8667)
TRICARE Retail Pharmacy Network	For questions about the TRICARE Retail Pharmacy Network	1-866-DoD-TRRx (1-866-363-8779)

Resource	Description	Contact Information
Pharmacy Services	For questions about pharmacy claims, pre-authorizations, and other inquiries	1-866-DoD-TRRx (1-866-363-8779)
Fraud and Abuse Hotline	To report suspected fraud or abuse	1-800-333-1620
Behavioral Health Partner—ValueOptions	For questions and information about mental health and substance use services	ValueOptions P.O. Box 551188 Jacksonville, FL 32255-1188 1-800-700-8646 **Fax Numbers** Appeals and Reconsiderations: 1-904-996-2188 MTF Referrals: 1-904-996-2060 Inpatient Records/Retrospective Review: 1-904-996-2059 Outpatient Treatment Reports (OTR): 1-904-996-2059 Retrospective Review of OTR: 1-904-996-2059 Provider Network Credentialing: 1-904-996-2108
Behavioral Health Claims	For information or submission of behavioral health claims	TRICARE South Region: Behavioral Health P.O. Box 7034 Camden, SC 29020-7034 1-800-403-3950
TRICARE Prime Remote/Supplemental Health Care Program	To obtain authorizations for patients in the TRICARE Prime Remote or Supplemental Health Care Programs	1-877-249-9179
ICD-9 Diagnosis Coding Manual and HCPCS Procedure Coding Manual	To receive copies or if you need assistance	1-801-982-3000 Ingenix 5225 Wiley Post Way, Suite 500 Salt Lake City, UT 84116 www.ingenixonline.com
CPT Procedural Coding Manual	To receive copies or if you need assistance	1-800-621-8335 American Medical Association P.O. Box 10950 Chicago, IL 60610
InterQual Criteria Guidelines	For information and assistance with InterQual Criteria Guidelines	InterQual, Inc. Director for Copyright Licensing 293 Boston Road West Marlborough, MA 01752
Military Medical Support Office (MMSO)	For written or phone inquiries to Army, Navy, Air Force, Marine Corps, Coast Guard, and National Guard	1-888-647-6676 (insert branch of service) Point of Contact Military Medical Service Office P.O. Box 886999 Great Lakes, IL 60088-6999
National Oceanic and Atmospheric Administration (NOAA) and U.S. Public Health Services (USPHS)	For written or phone inquiries to NOAA or USPHS	1-800-368-2777 NOAA/USPHS Point of Contact Medical Affairs Branch Beneficiary Medical Program 5600 Fishers Lane, Room 4C-06 Rockville, MD 20587

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Policies, procedures, and guidance for TRICARE providers

Important Provider Information

TRICARE Policy

Provisions of the U.S. Constitution authorize Congress to make laws by passing an "Act" (e.g., Defense Appropriations Act of 1999). When an act is passed, it becomes a federal law, which generally supercedes any state law (unless it specifies that a state law may apply). An act can be codified in a number of statutes. These statutes are classified and coded in the United States Code. Title 10 of the United States Code houses all statutes regarding the armed forces.

When an act relevant to TRICARE becomes law, the Department of Defense (DoD) directs Humana Military Healthcare Services, Inc. (Humana Military) on the manner in which that law should be administered. This direction comes through modifications to federal regulations (e.g, the code of federal regulations (CFR), the TRICARE Operations Manual, TRICARE Reimbursement Manual, and the TRICARE Policy Manual). Depending on the complexity of the law, it can take a year or more before direction from the DoD is given and Humana Military can begin administration of the new policy. For additional information, refer to the TRICARE manuals at www.tricare.osd.mil.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996, to combat waste, fraud, and abuse; improve portability of health insurance coverage; and simplify health care administration. All health plans, health care clearinghouses, and health care providers who conduct certain financial and administrative transactions electronically must comply with HIPAA. The TRICARE health plan, military treatment facilities (MTFs), providers, the TRICARE contractors, subcontractors, clearinghouses, and other business associates fall within these categories.

In compliance with the portability portion of the HIPAA, the Military Health System (MHS), through the Defense Manpower Data Center Support Office (DSO), issues Certificates of Creditable Coverage automatically to beneficiaries who lose TRICARE coverage.

Under the Administrative Simplification portion of the HIPAA, the Department of Health and Human Services (HHS) has published five rules for HIPAA compliance:

- Transactions and Code Sets Rule, published August 17, 2000. Compliance date: October 16, 2003.
- Privacy Rule, published December 28, 2000. Compliance date: April 14, 2003.
- Employer Identifier Rule, published May 31, 2002. Compliance date: July 30, 2004.
- Security Rule, published February 20, 2003. Compliance date: April 21, 2005.
- National Provider Identifier Rule, published January 23, 2004. Compliance date: May 23, 2007.

Effective April 14, 2003, the HIPAA Privacy Rule provisions were implemented nationwide and all covered entities, including providers, were required to be in full compliance with the Privacy Rule.

Effective October 16, 2003, HIPAA standard electronic transactions were implemented within the MHS.

Guidelines for Implementing the HIPAA Privacy Rule

As required by the HIPAA Privacy Rule, provider offices/groups must train all members of their workforces on the policies and procedures with respect to protected health information (PHI) as necessary to carry out their function. Appropriate safeguards must be in place that provide security to PHI from an administrative, technical, and physical standpoint. Providers must reasonably safeguard PHI from any intentional or unintentional use or

disclosure that is in violation of the standards, implementation specifications, or other requirements of the standard.

Providers are permitted by the HIPAA Privacy Rule to make use and disclosure of an individual's PHI for purposes of treatment, payment, and health care operations. PHI is the information created and obtained as providers deliver services to beneficiaries. Such information may include documentation of symptoms, examination and test results, diagnoses, treatments, and applying for future care or treatment. It also includes billing documents for those services.

In addition, providers are permitted to use PHI for health care operations without being required to obtain a release or authorization for activities, such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance.

Disclosures that do not have to be included for the HIPAA Privacy Rule include:

- Releases for treatment, payment, or health care operations
- Releases to the individual
- Releases occurring with patient's written authorization
- Releases for the directory or other persons involved in the individual's care
- Releases to national security or intelligence agencies
- Releases to correctional institutions or law enforcement

HIPAA requires that all PHI be kept completely confidential. PHI is defined as information about individuals or beneficiaries which contains the following data:

- Home address
- Home telephone number
- Race
- Social security number
- Medical records
- Photographs
- Any information that may compromise the privacy of or prove harmful to the beneficiary

Some state laws contain more stringent requirements than those required by the federal regulation under HIPAA. Providers must be familiar with both federal and state regulations and comply with their requirements in their entirety.

To maintain confidentiality, HIPAA and other federal laws preclude Humana Military, PGBA, and ValueOptions employees from providing information to parents or guardians of minors, or persons who are unable to make health care decisions for themselves, when the services are related to alcoholism, abortion, drug abuse, venereal disease, or HIV.

Additional guidance about the release of patient information is found later in this section under "Provider Responsibilities."

Military Health System Notice of Privacy Practices

The MHS Notice of Privacy Practices informs beneficiaries how PHI may be used or disclosed. It describes safeguards in place to protect PHI and explains patient privacy rights. The notice has been published in nine languages, including braille, and an audio version is available for vision-impaired beneficiaries.

Privacy officers are located at every MTF. They serve as beneficiary advocates for privacy issues and will respond to inquiries from TRICARE beneficiaries regarding their PHI. Beneficiaries may contact their privacy officer if they have questions about the notice of privacy practice or about their privacy rights. Beneficiaries may also visit the TRICARE Web site at www.tricare.osd.mil/hipaa for more information about the notice of privacy practices or other HIPAA requirements. Specific questions about HIPAA may be sent via e-mail to hipaamail@tma.osd.mil.

If you or your staff would like copies of the MHS Notice of Privacy Practices, visit the TRICARE Web site at www.tricare.osd.mil.

HIPAA Transactions and Code Sets

The HIPAA Transactions and Code Sets Rule has mandated the use of electronic standards for certain administrative and financial health care transactions. Compliance with this rule was mandated for October 16, 2003.

The table below lists the mandated HIPAA electronic transactions.

Transaction No.	Transaction Standard
X12N 270/271	Eligibility/Benefit Inquiry and Response
X12N 278	Referral Certification and Authorization
X12N 837	Claims: (Institutional, Professional, and Dental) and Coordination of Benefits (COB)
12N 276/277	Claim Status Request and Response
X12N 835	Payment and Remittance Advice
X12N 834	Enrollment/Disenrollment in a Health Plan
X12N 820	Payroll Deduction for Insurance Premiums
NCPDP Telecom Std. Ver. 5.1	Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response
NCPDP Batch Std. Ver. 1.1	Retail Pharmacy Drug Claims, COB, Referral Certification and Authorization, Eligibility Inquiry and Response
TBD	Claims Attachments
TBD	First Report of Injury

The MHS and the TRICARE program are now HIPAA compliant with standard transactions and code sets. Where these business functions are performed electronically, the HIPAA standards are now in use. For more information, visit the TRICARE HIPAA Web site at www.tricare.osd.mil/hipaa.

HIPAA National Provider Identifier

The HIPAA National Provider Identifier (NPI) Final Rule, published in the Federal Register January 23, 2004, adopts the NPI as the standard unique identifier for health care providers. The rule becomes effective May 23, 2005, and the MHS and TRICARE must be compliant by May 23, 2007. All entities who meet the definition of "health care provider" are eligible for NPIs. However, providers who are "covered entities" are required to obtain and use NPIs.

Enumeration of the NPI will be through the National Provider System (NPS), which is being built under a contract for the Department of Health and Human Services (HHS). The NPS will be a central system for identifying and uniquely enumerating health care providers at the national level and will assign NPIs to health care providers. Enumeration can begin after the effective date of May 23, 2005.

The NPI is a 10-position, all-numeric identifier that is easily accommodated in all HIPAA standard electronic transactions. NPIs will not contain intelligence about the provider. For enumeration purposes, there will be two categories of health care providers. Entity Type Code 1 is for individuals, such as physicians, nurses, dentists, chiropractors, pharmacists, and physical therapists. Entity Type Code 2 is for organizations, such as hospitals, home health agencies, clinics, nursing homes, laboratories, and MTFs.

Over the course of the next year, TMA will be addressing requirements and policy issues related to enumerating providers and use of the NPI within the MHS.

HIPAA Employer Identifier

The National Employer Identifier Final Rule was published on May 31, 2002. Covered entities must be compliant with the rule by July 30, 2004. For HIPAA purposes, employers are defined as the sponsors of health insurance for their employees. The standard selected for the national employer identifier is the Employer Identification Number (EIN) as issued by the Internal Revenue Service (IRS). This number is

the EIN that appears on an employee's IRS Form W-2, Wage and Tax Statement, and is the number that will be used to identify that employer in standard electronic health care transactions. Covered health care providers, health plans, and health care clearinghouses must accept and transmit the EIN where required in electronic health transactions.

TRICARE Provider Types

TRICARE defines a provider as a person, business, or institution that provides or gives health care. For example, a doctor is a provider. A hospital is a provider. An ambulance company is a provider. There are many other types. A provider must be authorized under the TRICARE Regulation and must have their authorized status verified (certified) by Humana Military.

Please note that active duty service members and civilian employees of the Federal Government who are health care providers are generally not authorized to be TRICARE providers in civilian facilities. So, if a TRICARE beneficiary sees a provider in a civilian facility that they know works at an MTF, they should check to ensure that TRICARE will provide reimbursement. Below are some classifications of providers.

Authorized Providers

An authorized provider is a hospital or institutional provider, a physician or other individual professional provider, or other provider of services or supplies who meets the licensing and certification requirements of TRICARE in 32 CFR 199.6 and is practicing within the scope of that license. Any physician listed in the 32 CFR 199.6 who holds a valid license to practice medicine in the state where he/she practices shall be an authorized provider. Providers not specifically listed in 32 CFR 199.6 are not considered authorized providers unless they are included in a TRICARE demonstration project.

Certified Providers

A hospital or institutional provider, physician, or other individual professional provider of services or supplies specifically authorized by 32 CFR 199.6. Certified providers have been verified by TRICARE Management Activity (TMA) or Humana Military to meet the standards of 32 CFR 199.6 and have been approved to provide services to TRICARE beneficiaries and receive government payment for services rendered to TRICARE beneficiaries.

Network Providers

A network provider is one who serves TRICARE beneficiaries through a contractual agreement with Humana Military as a member of the TRICARE network or any other preferred provider network or by any other contractual agreement with Humana Military. A network provider accepts the negotiated rate as payment in full for services rendered and always files claims for the beneficiary.

Non-network Providers

A non-network provider is one who has no contractual relationship with Humana Military to provide care to TRICARE beneficiaries but is certified. Payment cannot be made to non-certified (unauthorized) providers. There are two types of non-network providers– "participating" and "nonparticipating."

Participating Providers

Providers who participate in TRICARE, also called "accepting assignment," agree to accept the TRICARE-determined allowable cost or charge as the total charge for services—also known as the TRICARE allowable charge—as the full fee for care. In the case of network providers, the negotiated rate is considered the TRICARE allowable charge. Non-network, individual providers may participate on a case-by-case basis. Providers may seek applicable copayments or cost-shares and deductibles from the beneficiary. Hospitals that participate in Medicare must, by law, also participate in TRICARE for inpatient care. For outpatient care, they may or may not participate.

Nonparticipating Providers

A nonparticipating provider is a certified hospital, institutional provider, physician, or other provider that furnishes medical services or supplies to TRICARE beneficiaries, but who has not signed a contract with Humana Military and does not agree to "accept assignment."

Provider Responsibilities

When a provider signs a TRICARE contract and becomes a Humana Military TRICARE provider, he/she agrees to adhere to all contract requirements.

Return of Consult Reports

Network specialty providers are required to return consult reports or results to the PCM and/or referring provider within 10 working days of all routine referrals.

Appointment Access Standards

One of the contract requirements for all network providers is to meet all office and appointment access standards. Those standards are as follows:

- Emergency services must be available 24 hours a day, seven days a week
- Maximum wait times for appointment are:
    - One day for acute illness
    - One week for routine visits (health problems that are non-urgent)
    - Four weeks for wellness (preventive health) visits
    - Wait time for specialty care appointments will be based on the nature of the care required, but will not exceed four weeks (28 days). The primary care manager determines the level of urgency.
    - Office waiting times for non-emergency situations will not exceed 30 minutes. Providers who are not able to adhere should notify the patient and offer to reschedule.
- Patients calling after hours who are not suffering from conditions requiring emergency care should be offered the following guidance:
    - Put in contact with an on-call network physician covering for you or your practice
    - Offered self-care advice
    - Offered a next day appointment when appropriate
    - Directed to an urgent care center that participates in the TRICARE program

Reporting Changes

It is important for Humana Military to have the most current and accurate data concerning your practice to facilitate timely claims payment and correspondence. Please notify Humana Military of any changes in your status, address, phone, or fax numbers by entering the changes online at www.humana-military.com or notifying the provider relations representative at your local TRICARE Service Center.

Balance Billing

Network providers may only bill TRICARE beneficiaries for applicable deductible, copayment, or cost-sharing amounts, but may not bill for charges that exceed contractually allowed payment rates. Because network providers have contractually agreed to adhere to these provisions, TRICARE beneficiaries will be referred first to a network provider. Any provider who is uncertain about the amount that may be billed to a TRICARE beneficiary may call Humana Military's TRICARE Service Line at 1-800-444-5445. The beneficiary's responsibility is reflected on the explanation of benefits (EOB) or the provider's remittance advice.

Non-network providers who accept assignment are limited to collecting the TRICARE allowable charge. If the billed charge is less than the allowable charge, the billed charge becomes the billable amount to the beneficiary. Balance billing applies only to services covered by TRICARE. A general statement of financial liability does not meet TRICARE criteria.

When providers do not accept assignment on a claim, non-network, nonparticipating providers can collect applicable deductibles and/or cost-shares and any outstanding amounts up to 15 percent above the allowable charge (shown on the remittance advice) from a TRICARE Standard beneficiary. If the billed charge is less than the TRICARE-allowed amount, the billed charge becomes the billable amount to the beneficiary.

Balance billing applies only to services covered by TRICARE. TRICARE's balance-billing limit also applies when other health insurance (OHI) is involved. Providers are limited to collecting the amount described above, regardless of the beneficiary's OHI financial responsibility.

When OHI is involved, the provider of care may receive no more than the TRICARE allowable charge, or if a non-network, nonparticipating provider, 115 percent of the allowable charge through payment by the other health insurer and TRICARE. Providers may not collect any amount from a beneficiary after payment of the claim unless TRICARE and the OHI combined have failed to pay the allowable charge. In the case of a network provider, the contractually negotiated amount is the allowable charge.

Non-compliance with these balance billing requirements by any TRICARE provider may affect that provider's TRICARE and/or Medicare status. Additional information on this topic may be obtained by visiting www.tricare.osd.mil.

Release of Patient Information

If an inquiry is made by a beneficiary, including an eligible dependent child, regardless of age, the reply should be addressed to the beneficiary, not the beneficiary's parent or guardian. The only exceptions are:

- When a parent writes on behalf of a minor child (under 18 years old)
- When a guardian writes on behalf of a physically or mentally incompetent beneficiary

In responding to a parent or guardian in the above circumstances, the Privacy Act of 1974 precludes disclosure of sensitive information which, if released, could have an adverse effect on the beneficiary.

Providers must not furnish information to the parents or guardians of minors or incompetents when services are related to the following diagnostic codes:

AIDS:
ICDM-9-CM 079.53; 042
Alcoholism:
ICDM-9-CM 291.9; 303-303.9; 305
Abortion:
ICDM-9-CM 634-639.9; 779.6
Drug Abuse:
ICDM-9-CM 292-292.2; 304-304.9; 305.2-305.9
Venereal Disease:
ICDM-9-CM 090-099.9; 294.1

TRICARE beneficiaries must maintain a "signature on file" in the physician's office to protect the patient's privacy, for the release of important information, and to prevent fraud. A new signature is required every year for professional claims submitted on a CMS-1500 and every admission for claims submitted on a UB-92. Claims submitted for diagnostic tests, test interpretations, or other similar services do not require the beneficiary's signature. Providers submitting these claims must indicate "patient not present" on the claim form.

Mentally incompetent or physically disabled TRICARE beneficiaries 18 years of age and older who are incapable of providing a signature may have a legal guardian appointed or a power of attorney issued on their behalf. This legal documentation must include the guardian's signature, full name, address, relationship to patient, and reason the patient is unable to sign.

The first claims submission on behalf of the beneficiary should include the legal documentation establishing the guardian's signature authority. Subsequent claims may be stamped with "Signature on File" in the beneficiary signature box of the CMS-1500 or UB-92 claim form.

- If the beneficiary is without legal representation, the provider must submit a written report with the claims describing the patient's illness or degree of mental competence, and should annotate in Box 12, "Patient's or Authorized Representative's Signature—Unable to Sign."
- If the beneficiary's illness is temporary, the signature waiver must specify the dates the illness began and ended.
- When the beneficiary is mentally competent but physically incapable of a signature, the representative may be issued a general or limited power of attorney by signing an "X" in the presence of a notary public.

Release of Medical Records

All providers are required to request that the TRICARE beneficiary sign a release of medical information at each office visit (unless a signed release is on file), to include ancillary services

associated with each visit whereby the primary care manager (PCM) and/or the MTF commanders are designated as the recipients of the medical records. For an urgent care visit, the records should be given to the beneficiary at the time of the visit. Providers are required to submit beneficiary records for review upon request.

Under the TRICARE Prime Remote program (described in the section titled "TRICARE Program Options"), active duty service members will be instructed to sign annual medical release forms with their PCM or TRICARE-certified providers to allow information to be forwarded to civilian and military providers. If an active duty service member is reassigned to a new location, the PCM shall provide complete copies of medical records and specialty and ancillary care documentation to the service member within 30 calendar days of the request—prior to moving.

Hold Harmless Policy

TRICARE beneficiaries must be properly informed in advance and in writing of specific services or procedures that are not covered under TRICARE before they are provided. If they choose, beneficiaries may sign a waiver agreeing to pay for non-covered services. However, if the provider does not obtain a legal signed waiver, and the care is not authorized, the provider is expected to accept full financial liability for the cost of the care. In addition, the waiver signed by a beneficiary after the care is rendered is not valid under TRICARE regulations. For the beneficiary to be considered fully informed, TRICARE regulations require that:

- The agreement is documented prior to the specific non-covered services being rendered.
- The agreement is in writing.
- The specific treatment and date(s) of service and billed amounts are documented.

General agreements to pay, such as those signed by the beneficiary at any time of admission, are not evidence that the beneficiary knew specific services were excluded or not allowable. Providers should maintain copies of the waiver in their office and fully inform beneficiaries in advance when specific services or procedures are not covered. See section titled "Medical Coverage" for a summary of TRICARE covered and non-covered services and benefits.

Waivers of Non-covered Services

A network provider can utilize the waiver of non-covered services when the beneficiary is properly informed, in advance, that TRICARE does not cover a particular service and he or she agrees in writing to be financially responsible. Non-covered services are considered TRICARE exclusions and limitations. Waiver of Non-covered Services forms are included in the Humana Military Network Provider Welcome Kits.

Veterans Affairs and CHAMPVA

Providers will be reported to the Department of Veterans Affairs (DVA) and to Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) as a TRICARE network provider. The DVA has the right to directly contact the provider and request care on a case-by-case basis for VA patients or CHAMPVA beneficiaries if the provider is available. The provider is not required to meet access standards for CHAMPVA beneficiaries, but are encouraged to do so. The provider rates applicable to their TRICARE contract DO NOT apply to the DVA referrals and the provider is free to negotiate with the DVA. The CHAMPVA beneficiaries are not to receive preferential appointment scheduling over a TRICARE beneficiary.

Quality Management

Humana Military and its subcontractors ensure physicians, licensed independent practitioners, and other health care professionals within the TRICARE network meet credentialing criteria. Adherence to credentialing criteria that meets or exceeds requirements of the DoD ensures a quality health delivery system for TRICARE.

Once approved for participation, each provider is monitored for quality of care and adherence to DoD and Humana Military standards. Humana Military uses several methods to monitor quality, including:

- Complaints and grievances
- Focused clinical quality and preventive health studies

Humana Military providers must agree to participate in clinical quality studies as needed, and they must also agree to make their medical records available for review for quality purposes. Each provider is recredentialed every three years. The recredentialing process also includes review of quality data.

Beneficiary Rights and Responsibilities

TRICARE beneficiaries need to understand their rights and their responsibilities. Both are listed below for your reference.

TRICARE Beneficiaries Have the *Right* to...

- Receive all covered, medically necessary care
- Receive complete and accurate information about the program through written materials, presentations, and from TRICARE representatives
- Have their medical information kept confidential
- Receive considerate, courteous care that is respectful of their privacy and dignity
- Receive and review information about diagnosis and treatment, and the progress of their condition
- Be involved in decisions about their treatment
- File a grievance in writing if they have a complaint that cannot be resolved informally
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage

TRICARE Beneficiaries Have the *Responsibility* to...

- Contact their PCM (if enrolled in TRICARE Prime) to receive treatment or a referral in nonemergency situations, including urgent situations
- Follow the prescribed medical instructions given by their PCM or other care provider
- Provide complete information about their health care status to their health care providers
- Participate in decisions about their treatment
- Read and understand all TRICARE materials
- Inform the Defense Manpower Data Center Support Office and Humana Military of status change(s)
- Provide information concerning OHI
- Follow prescribed procedures for TRICARE Prime enrollment portability when moving to another TRICARE region
- Inform contractor(s) of TRICARE Prime split-enrollment status

Military Treatment Facilities

A military treatment facility (MTF) is a military hospital or clinic on or near a military base. The contracted provider network augments the resources available in the MTF.

Network providers may work closely with MTF providers near them. For an accurate, up-to-date listing of the MTFs in the South Region, visit the Humana Military Web site at www.humana-military.com or visit the MTF Locator at www.tricare.osd.mil/mtf.

Priorities for Care

Beneficiaries may receive care in the MTF in the following order of priority:

- Active duty service members (ADSMs)
- Active duty family members (ADFMs) who are enrolled in TRICARE Prime (survivors of military sponsors who died on active duty who are enrolled in TRICARE Prime are included in this priority group during the time period they are eligible). ADFMs who are enrolled in TRICARE Plus fall into this category for primary care appointments only.

- Retirees, their family members, and survivors who are enrolled in TRICARE Prime
- ADFMs who are NOT enrolled in TRICARE Prime (survivors of military sponsors who died on active duty who are not enrolled in TRICARE Prime are in this priority group). These beneficiaries may enroll in the TRICARE Plus program to receive primary care within an MTF.*
- Retirees, their family members, and survivors who are not enrolled in TRICARE Prime. These beneficiaries may enroll in the TRICARE Plus program.*
- All other eligible beneficiaries

*See the section titled "TRICARE Program Options" for information about TRICARE Plus.

There are certain special provisions in the MTF access policy. Visit the TRICARE Web site at www.tricare.osd.mil for more details.

MTF First Right of Refusal

MTFs are given the first "right of refusal" for TRICARE Prime beneficiaries for inpatient admissions, specialty appointments, and procedures requiring prior authorizations. This means that TRICARE Prime beneficiaries must first try to obtain these services at an MTF. If the service is not available at the MTF within the appropriate access standards, then the beneficiary is referred to a TRICARE network provider.

Nonavailability Statements for Inpatient Care

A nonavailability statement (NAS) is a certification from an MTF stating that it cannot provide a specific required service at a particular time to a non-enrolled beneficiary. Effective for admissions on or after December 28, 2003, the NAS requirement was eliminated for all inpatient admissions except for mental health admissions.

An NAS may be required for services other than mental health admissions (except for maternity care) when:

- Significant costs would be avoided if the services are performed at the MTF.
- Specific procedures must be performed at the MTF to ensure proficiency levels of the providers at the MTF.
- The lack of NAS data would significantly interfere with TRICARE contract administration.

The general elimination of the NAS requirement should not be confused with the continuing requirement of an authorization for those services requiring prior authorization. Network providers should advise TRICARE beneficiaries to check with Humana Military to find out if a prior authorization is required before obtaining nonemergency inpatient services.

NAS for Maternity Care

An NAS is NOT required for any maternity episode when the first prenatal visit occurs on or after December 28, 2003.

If the first prenatal visit occurred prior to December 28, 2003 (October 5, 1999 through December 27, 2003), for a beneficiary who lives in an MTF catchment area ZIP code who is not enrolled in TRICARE Prime, an NAS is required for nonemergency health care services related to outpatient prenatal, outpatient or inpatient delivery, and outpatient postpartum care subsequent to the visit which confirms the pregnancy.

NAS for Newborns

An NAS is NOT required for newborns with admission or birth date of December 28, 2003, or after.

In the event that a non-enrolled newborn infant born or admitted before December 28, 2003, remains in the hospital after a mother's discharge, the mother's NAS will be valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond these 15 days, a valid NAS is required for nonemergency inpatient care in the infant's name.

Additional information about the elimination of the NAS requirement is available online at www.tricare.osd.mil/tricaremanuals/.

DoD Centers of Excellence Program

The DoD Centers of Excellence program provides an enhanced model of clinical quality oversight. Any MTF performing the covered diagnosis-related groups (DRGs) may apply to participate in the program. MTFs have the option of applying in conjunction with one or more medical facilities (restricted to MTFs and federal-civilian programs) with which they have an established relationship. For more information about becoming a DoD Center of Excellence, visit the DoD Centers of Excellence Web site at www.tricare.osd.mil/coe.

Notes

Notes

Understanding how eligibility for TRICARE is determined and your role in verifying a patient's eligibility

TRICARE Eligibility

TRICARE is available to eligible beneficiaries from any of the seven uniformed services—Army, Navy, Air Force, Marine Corps, Coast Guard, the U.S. Public Health Service, and the National Oceanic and Atmospheric Administration. All eligible beneficiaries must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS). Providers should ensure patients have a valid uniformed services (military) identification (ID) card or authorization letter of eligibility. Be sure to check the expiration date and make a copy of both sides of the ID card for your files. See samples of uniformed services (military) ID cards in the section titled "Provider Tools."

Beneficiaries can verify their enrollment in DEERS by calling 1-800-538-9552. As a provider, you may not verify DEERS enrollment directly because of the Privacy Act (5 U.S.C. 552a). Children under the age of 10 will probably not have an ID card. In these cases, providers should check the parent's ID card.

Important Notes about Eligibility

Family members of active duty service members lose their eligibility at midnight on the day the active duty sponsor is discharged from service, unless they have extended benefits through the Transitional Assistance Management Program.

Active duty service members *cannot* use TRICARE Standard or TRICARE Extra. They must enroll in TRICARE Prime. The service member's branch of service provides for the care of active duty service members and is responsible for paying for any civilian emergency care required by active duty members.

Special Eligibility Rules under Diagnosis-Related Groups

Under the TRICARE Standard diagnosis-related group (DRG) payment system, if a patient loses or gains eligibility during a hospitalization, the DRG hospital will be paid as if the patient were eligible during the entire admission. If the patient loses eligibility because of gaining Medicare eligibility, TRICARE becomes the secondary payer. For a patient who becomes eligible for Medicare because of age, and who is not an active duty family member, TRICARE's secondary pay status is for that claim only. However, a change in eligibility often will affect outlier payments. The patient's cost-share will be based on the status of the sponsor (active duty or retired) at the time of admission. For all other providers, including DRG-exempt hospitals, TRICARE Standard will share the cost of only that portion of the services or supplies that was rendered before eligibility ceased.

Dual-Eligibility

Some TRICARE beneficiaries are also eligible to receive other federal benefits, such as Medicare or Veterans Affairs (VA) health care benefits. The following section discusses these dual-eligible situations. If a beneficiary is not entitled to Medicare Part A, they will need a Notice of Disallowance from the Social Security Administration to remain eligible for TRICARE. The beneficiary will need to submit the Notice of Disallowance to DEERS to update their eligibility and receive an ID card that reflects continuing TRICARE coverage.

TRICARE and Medicare

TRICARE beneficiaries under age 65 who are also titled to Medicare Part A due to a disability or end-stage renal disease (ESRD) are considered dual-eligible. For these individuals, TRICARE coverage may continue as a secondary payer to Medicare. By law, dual-eligible beneficiaries under the age of 65 must be enrolled in Medicare Part B to retain TRICARE benefits. (The requirement to enroll in Medicare

Part B does not apply to dual-eligible ADFMs regardless of age.) All other dual-eligible beneficiaries must enroll in Medicare Part B, or they will not be eligible for coverage under TRICARE.

These dual-eligible beneficiaries may maintain their regular TRICARE eligibility (TRICARE Prime, TRICARE Extra, or TRICARE Standard). By law, TRICARE will pay secondary to Medicare for these beneficiaries, similar to TRICARE For Life (TFL). Dual-eligible beneficiaries are not required to pay TRICARE Prime enrollment fees. Since 1991, beneficiaries who are under age 65 and eligible for TRICARE and have Medicare Part A and Part B have been able to use TRICARE as a secondary payer to Medicare.

When TRICARE beneficiaries become titled to Medicare Part A upon attaining the age of 65 and purchase Medicare Part B, they become eligible for TFL, and TRICARE will pay secondary to Medicare. Information about TFL is available in the section titled "TRICARE Program Options."

TRICARE and Veterans Affairs

In some cases, beneficiaries are eligible for benefits under both the TRICARE and VA programs. These beneficiaries may choose to use their TRICARE benefit at a VA medical facility as long as the service is covered under TRICARE and is not for a service-connected condition. Veterans who choose to use TRICARE must comply with the TRICARE program rules. Care received in a VA facility for service-connected conditions must be received under veterans' benefits.

If a TRICARE/VA dual-eligible beneficiary is seeking care in a facility other than a VA facility (MTF, civilian hospital, etc.), he/she may choose to use TRICARE benefits regardless of whether it is for a service-connected condition. However, once that choice is made, the TRICARE benefit must be used to complete the entire "episode of care." An episode of care generally includes all covered services provided for a particular medical incident.

Notes

Notes

A description of TRICARE's family of health care programs and options available to TRICARE beneficiaries

TRICARE Program Options

TRICARE's family of programs offers comprehensive medical and dental benefits to every TRICARE beneficiary category. It's important to understand the choices available and how you as a provider can assist beneficiaries in making the right choice.

TRICARE Prime

TRICARE Prime is a managed care option. TRICARE Prime offers fewer out-of-pocket costs than any other TRICARE option. TRICARE Prime beneficiaries who are enrolled to a civilian Primary Care Manager (PCM) receive most of their care from the civilian PCM who provides and coordinates for care, maintains patient health records, and refers patients to specialists, if necessary. TRICARE Prime beneficiaries who are enrolled to a military treatment facility (MTF) PCM receive most of their care from an MTF, augmented by the Humana Military Healthcare Services, Inc. (Humana Military) provider network. Specialty care must be arranged and approved by Humana Military to be covered under TRICARE Prime.

Active duty service members (ADSMs) are not responsible for any copayments. ADFMs enrolled in TRICARE Prime do not have copayments, except for pharmacy copayments, when using the TRICARE Prime point-of-service (POS) option or when enrolled in Program for Persons with Disabilities (PFPWD). Retirees and their families enrolled in TRICARE Prime are responsible for copayments when seeking care from a network provider. TRICARE Prime beneficiaries are not responsible for annual deductibles.

Eligibility for TRICARE Prime

TRICARE Prime is available to ADSMs, family members, and survivors of active duty personnel; retirees, their family members, and survivors under age 65; and members of the Reserve Component (RC) and their families (if the RC member is activated for more than 30 consecutive days). All eligible beneficiaries must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) and reside in a service area where TRICARE Prime is offered.

TRICARE Prime beneficiaries will present their TRICARE Prime enrollment card and uniformed services (military) identification (ID) card at the time of service. See an example of the TRICARE Prime enrollment card in the section titled "Provider Tools."

Eligibility may be verified by calling Humana Military at 1-800-444-5445. Eligibility is also verified as part of the prior authorization process.

Primary Care Manager

TRICARE Prime enrollees select or are assigned a PCM. A PCM is an MTF provider or a TRICARE network provider within a TRICARE Prime service area who provides primary care services to TRICARE Prime beneficiaries.

According to TRICARE, a PCM who is practicing within the governing State's rules and regulations may be a provider of primary care services when rendering services within a Prime Service Area location. This includes the following PCM types:

- Internal medicine physicians
- Family practitioners
- Pediatricians
- General practitioners

A TRICARE Prime beneficiary relies on his/her PCM for referrals to specialty care providers and services either at an MTF or within the local network. For these services to be covered by TRICARE, the network PCM must submit a referral request.

There is no requirement for a PCM referral and/or authorization for those services provided by the PCM in his/her office or for emergency care.

Local health care finders (HCFs) at the TRICARE Service Centers (TSCs) will assist with finding specialty care after a referral is requested. TRICARE Prime beneficiaries may be reimbursed for reasonable travel expenses if an HCF authorizes a referral to a specialist who is more than 100 miles away from the PCM's office. TRICARE Prime enrollees are required to obtain all care either from their PCM or with referrals from network providers. ValueOptions will issue a referral to a non-network provider on a case-by-case basis when a network behavioral health provider is unavailable. Refer to the section titled "Health Care Management and Administration" for more information about referrals and authorizations.

Point-of-Service Option

TRICARE Prime beneficiaries who utilize the POS option may self-refer to any TRICARE-certified (network or non-network) provider for medical or surgical services without a referral from his/her PCM. For behavioral health services, the POS option applies when the TRICARE Prime beneficiary receives nonemergency services from a non-network provider. Although a referral is not required when using the POS option, certain prior authorization requirements still apply. The beneficiary will pay a deductible ($300 individual and $600 family) and 50 percent of the TRICARE allowable charge. There is no catastrophic cap protection when using the POS option. Special considerations apply if the beneficiary has other health insurance.

The POS option is exercised only when the beneficiary chooses to proceed with care without a required referral or when a provider has failed to obtain an authorization for specialty care prior to rendering it under nonemergency circumstances. It is important for providers to note the end date of referrals and to advise beneficiaries when additional referrals are required.

TRICARE Extra and TRICARE Standard

TRICARE Extra and TRICARE Standard are available for all TRICARE-eligible beneficiaries who choose not to enroll in TRICARE Prime. ADSMs are not eligible for TRICARE Extra or TRICARE Standard. Beneficiaries are responsible for fiscal year deductibles and cost-shares. Beneficiaries may see any TRICARE-certified provider they choose, and TRICARE will share the cost with the beneficiaries after deductibles are met.

TRICARE Extra is a preferred provider option in which beneficiaries choose a doctor, hospital, or other medical provider within the Humana Military provider network.

TRICARE Standard is a fee-for-service option. Beneficiaries may seek care from any TRICARE-certified provider. The following chart shows the main differences between TRICARE Extra and TRICARE Standard out-of-pocket cost-share deductibles.

	TRICARE Extra	TRICARE Standard
Physician/ Provider	In network	Not in network, but still a certified provider
Cost-share after deductibles	15% for active duty families 20% for retirees and their families	20% for active duty families 25% for retirees and their families

Catastrophic Cap Benefit

TRICARE beneficiaries have a catastrophic cap that limits their out-of-pocket liability on copayments, cost-shares, and deductibles.

- Active duty family members enrolled in TRICARE Prime or utilizing TRICARE Extra or TRICARE Standard benefits have a catastrophic cap of $1,000 per fiscal year.
- All other TRICARE Prime beneficiaries (retirees, family members of retirees, survivors, former spouses) have a catastrophic cap of $3,000 per enrollment period, which is only applicable to enrollment fees, outpatient and inpatient cost-shares, and copayments. POS cost-shares and the deductible shall not be applied to the TRICARE Prime beneficiary's

$3,000 catastrophic cap limit, but will be applied to his/her fiscal year catastrophic cap of $3,000.

- The TRICARE Prime beneficiary's out-of-pocket cost while utilizing POS is accrued against the catastrophic cap. However, there is no cap on POS out-of-pocket expenses. The beneficiary cost-share will remain at 50 percent of the TRICARE allowable charge even after the catastrophic cap has been reached.
- TRICARE Standard beneficiary families (retirees, dependents of retirees, survivors, former spouses) have a catastrophic cap of $3,000 per fiscal year.

TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members

TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) provide health care coverage through civilian network or TRICARE-certified providers for ADSMs and their families who are on remote assignment, typically 50 miles or a one hour drive time from an MTF. TPR and TPRADFM are offered in the 50 United States only, and both require enrollment with Humana Military for participation.

Similar to TRICARE Prime, TPR and TPRADFM beneficiaries choose a PCM to provide primary care services and coordinate specialty care. In some cases, however, TPR and TPRADFM may have to choose a non-network TRICARE-certified provider as their PCM if there are no network providers in their area. These beneficiaries can also receive services from military providers, if they are willing to travel to the MTF.

ADSMs can receive primary care services without a referral, prior authorization, or fitness-for-duty review. Specialty and inpatient care will require a referral and prior authorization. Those who do not have a PCM must coordinate requests for specialty care through Humana Military and the Service Point of Contact (SPOC). The SPOC will determine if the specialty care should be referred to a military physician for a fitness-for-duty determination or to a TRICARE-certified provider. Contact Humana Military at 1-800-444-5445 or visit the Humana Military Web site at www.humana-military.com for more information or assistance.

Active duty service members (ADSMs) assigned to a civilian PCM require a PCM referral for behavioral health care. ADSMs with an unassigned PCM will need to contact ValueOptions at 1-800-700-8646 for behavioral health care. Providers fax Outpatient Treatment Reports (OTRs) for additional outpatient visits to ValueOptions at 1-904-996-2059. Clinical information is entered into the authorization system and this information is electronically forwarded to the Military Medical Support Office (MMSO), who reviews each TPR request for services before an authorization number is given to the PCM or ADSM (for the behavioral health provider).

Using the POS Option

Providers seeing patients who are identified as TPRADFM patients are subject to the same POS provisions as those that are listed under TRICARE Prime. The only difference is that the TPRADFM patient has chosen his/her own PCM and does not have to see network providers. Non-network participating providers may treat these patients with a referral from Humana Military. The same listing of no-referral medical procedures and clinical preventive services applies.

TRICARE For Life

TRICARE For Life (TFL) is a program option available for uniformed services retirees, their spouses, and survivors age 65 and over who are titled to Medicare Part A and enrolled in Medicare Part B. TFL is available as secondary coverage to Medicare in addition to offering access to TRICARE services that may not be covered under Medicare. TRICARE pays secondary to Medicare beginning on the first day of the month that the beneficiary turns 65.

In most cases, Medicare will pay first, and the remaining out-of-pocket expenses will be paid by TRICARE. Wisconsin Physicians Service (WPS) administers TFL.

Covered Services

- For TRICARE and Medicare-covered services, Medicare pays first in most cases, and TRICARE pays its share of the remaining expenses second.
- For services covered by TRICARE, but not by Medicare, TRICARE pays first and the beneficiary is responsible for any TRICARE deductibles and cost-shares.
- For services covered by Medicare, but not by TRICARE, Medicare is the only payer and the beneficiary is responsible for Medicare cost-shares.
- For services not covered by Medicare or TRICARE, the beneficiary is responsible for all costs.

For services received from a civilian provider, the provider will first file claims with Medicare. Medicare will pay its portion and automatically forward the claim to TRICARE for processing. TRICARE will send its payment for the remaining beneficiary liability directly to the provider, and beneficiaries will receive a Medicare summary notice and a TFL explanation of benefits (EOB) that indicates the amount paid to the provider. See the description about filing dual-eligible claims in the section titled "Claims Processing and Billing Information."

TRICARE Plus

TRICARE Plus is a primary care enrollment program that is offered at selected MTFs. All beneficiaries eligible for care in MTFs (except those enrolled in TRICARE Prime, a civilian HMO, or Medicare HMO) can seek enrollment for primary care at MTFs where the enrollment capacity exists. Non-enrollment in TRICARE Plus does not affect TFL benefits or other existing programs. Beneficiaries should contact their local MTF to find out if they may participate in TRICARE Plus.

TRICARE Pharmacy Program

TRICARE provides a world-class pharmacy benefit. TRICARE beneficiaries are eligible for the TRICARE Pharmacy Program, including Medicare-eligible beneficiaries age 65 and over, and can fill prescription medications at MTF pharmacies, through the TRICARE Mail Order Pharmacy (TMOP), or at retail network and non-network pharmacies. All beneficiaries must have their address and other information updated in DEERS. To have a prescription filled, beneficiaries will need a written prescription and a valid uniformed services ID card. Medicare-eligible beneficiaries who turned age 65 on April 1, 2001, or later, must be enrolled in Medicare Part B.

Generic Drug Use Policy

It is a Department of Defense (DoD) policy to substitute generic medications for brand-name medications when available. Brand-name drugs that have a generic equivalent may be dispensed only if the prescribing physician is able to justify medical necessity for use of the brand-name drug in place of the generic equivalent. If a generic equivalent drug does not exist, the brand-name drug will be dispensed at the brand-name copayment.

Drug/Medication Coverage

The DoD Pharmacy and Therapeutics Committee has established quantity limits on certain medications, which means that DoD will pay only for up to a specified quantity per 30-, 60-, or 90-day supply. Quantity limits are applied to address the problem of overuse of medications that can be unsafe for the patient and costly to the government. Exceptions to established quantity limits can be made if the prescribing physician is able to justify medical necessity.

Certain medications, such as Enbrel, Lamisil, Sporanox, and Viagra, require prior authorization before they can be obtained from a retail pharmacy under the TRICARE program. A prior authorization request is necessary to ensure that clinically appropriate treatment regimens are followed. Drugs that require prior authorization are usually medications that are not the first step in a treatment regimen.

There are specific drugs for which DoD has awarded contracts with pharmaceutical manufacturers that apply to the MTF pharmacies and the mail order program. As a result, some drugs that can be obtained from a retail pharmacy cannot be obtained from MTF

pharmacies or the mail order program. Non-contracted medications, such as Lipitor, Prevacid, and Protonix, can only be dispensed from the mail order program when medical necessity is substantiated. However, they can be obtained at a retail pharmacy without medical justification and will be covered by TRICARE.

TRICARE covers all Food and Drug Administration (FDA) approved prescription drugs approved for outpatient use with some exclusions established by law. Additionally, some drugs require prior authorization. For a general list of prescription drugs that are covered under TRICARE's outpatient pharmacy benefit and for drugs requiring prior authorization or quantity limits at TRICARE retail network pharmacies, visit www.express-scripts.com/TRICARE or call 1-866-DoD-TRRx (1-866-363-8779). For a listing of FDA-approved drugs, visit the FDA Web site at www.fda.gov/cder/ob.

TRICARE Pharmacy Options

MTF Pharmacies

Prescriptions may be filled (up to a 90-day supply for most medications) at an MTF pharmacy free of charge. Each facility is required to make available the medications listed in the DoD basic core formulary. The MTF, through its local pharmacy and therapeutics committee, may add additional medications to its local formulary based on the scope of care at that MTF. Beneficiaries should contact their local MTF for specific details about filling and refilling prescriptions at its pharmacy. MTF pharmacies will accept written prescriptions from any TRICARE-certified provider.

TRICARE Mail Order Pharmacy (TMOP)

TMOP is available for prescriptions that beneficiaries take on a regular basis. Beneficiaries may receive up to a 90-day supply for most medications. TMOP is administered by Express Scripts, Inc. Through this program, beneficiaries mail (or providers may fax) their health care provider's written prescription along with the appropriate copay to TMOP, and the medications will be sent directly to the beneficiary. Prescriptions may be refilled by mail, phone, or online.

For more information about how to use TMOP, beneficiaries may visit the TRICARE Web site at www.tricare.osd.mil/pharmacy/tmop.cfm or contact TMOP member services at 1-866-DoD-TMOP (1-866-363-8667) within the U.S., or 1-866-ASK-4PEC (1-866-275-4732) outside the U.S. They may also visit the Express Scripts Web site at www.express-scripts.com/TRICARE.

TRICARE Retail Pharmacy Network

Beneficiaries may fill prescriptions at pharmacies in the TRICARE network. The TRICARE Retail Pharmacy Network is administered by Express Scripts, Inc. For more information, please contact Express Scripts, Inc. at www.express-scripts.com/TRICARE or call 1-866-DoD-TRRx (1-866-363-8779).

Non-network Pharmacies

Filling prescriptions in non-network pharmacies is the most expensive option and is not recommended. Beneficiaries may have to pay for the total amount first and file a claim to receive a partial reimbursement.

Pharmacy Copayments

Place of Service	Generic	Brand Name
MTF Pharmacy	$0	$0
TMOP (up to a 90-day supply)	$3	$9*
Retail Network Pharmacy (up to a 30-day supply)	$3	$9*
Non-network Pharmacy	1. $9* or 20% of total cost (whichever is greater) 2. Existing deductibles and point-of-service (POS) penalty apply: E-4 and below, TRICARE Standard, $50 per person/$100 per family; E-5 and above, TRICARE Standard, $150 per person/$300 per family; TRICARE Prime, $300 per person/$600 per family, POS penalty–50% of the allowed amount.	

**Some prescriptions may be classified as "non-formulary." In these cases, you will be responsible for a $22 cost-share with TMOP or in the TRICARE retail pharmacy network. In non-network pharmacies, you will be responsible for a $22 cost-share or 20 percent, whichever is higher.*

Pharmacy Data Transaction Service

The Pharmacy Data Transaction Service (PDTS) creates a global centralized data repository that records information about prescriptions filled for DoD beneficiaries at MTFs, the TRICARE retail pharmacy network, and the TMOP program. PDTS improves the quality of prescription services and enhances patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic overlaps, and duplicate treatments across the highly transient population of active duty and retired beneficiaries. PDTS conducts an online prospective drug utilization review (a clinical screening) against a beneficiary's complete medication history for each new or refilled prescription in real-time before it is dispensed to the patient. Regardless of where a beneficiary fills a prescription within the MHS, information about the prescription is stored in a robust central data repository and is available to authorized PDTS providers as a seamless enhancement to the current workflow processes. The PDTS provides the means for application of benefit design rules for consistency across all points of service available to DoD beneficiaries.

TRICARE Dental Programs

TRICARE currently offers two dental programs to meet the needs of its beneficiary population: the TRICARE Dental Program and the TRICARE Retiree Dental Program.

TRICARE Dental Program

The TRICARE Dental Program (TDP) is a voluntary dental insurance program, administered and underwritten by United Concordia Companies, Inc. (UCCI), that is available to eligible active duty family members (ADFMs) and Selected Reserve and Individual Ready Reserve (IRR) members and their eligible family members. Active duty personnel (and Reservists called to active duty for a period of more than 30 days) are not eligible for the TDP. They receive dental care from military dental treatment facilities. Former spouses, parents, parents-in-law, disabled veterans, foreign military personnel, and uniformed services retirees and their families are not eligible for the TDP. Other details of TDP benefits, requirements, and restrictions can be found at the UCCI Web site at www.ucci.com/was/ucciweb/home.jsp.

TRICARE Retiree Dental Program

The TRICARE Retiree Dental Program (TRDP) is a voluntary dental insurance program administered and underwritten by the Federal Services division of Delta Dental Plan (DDP) of California. The TRDP offers comprehensive, cost-effective dental coverage for uniformed services retirees and their eligible family members, as well as certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors. Other details of TRDP benefits, requirements, and restrictions can be found at the DDP Web site at www.trdp.org.

TRICARE for the Reserve Component

Members of the Reserve Component (RC) who are called to active duty for more than 30 consecutive days are eligible for TRICARE, the same as any ADSM. Families of these individuals also become eligible for TRICARE if the sponsor is called to active duty for more than 30 consecutive days. To ensure family members are eligible for TRICARE upon activation, sponsors should register their family members in DEERS.

Programs Available to the Reserve Component

Family members of the RC become eligible for TRICARE Extra and TRICARE Standard on the first day of the military sponsor's active duty if his/her orders are for more than 30 consecutive days or if the orders are for an indefinite period. Family members must be enrolled in DEERS to document their eligibility. There is no enrollment required for TRICARE Standard or TRICARE Extra. There is an annual fiscal year deductible and cost-shares. They also become eligible for the TRICARE Pharmacy Program and may have prescriptions filled at MTF pharmacies, through the TMOP, or at retail pharmacies. The TRICARE Pharmacy Program has its own cost-shares separate and apart from all other programs.

Eligible family members may enroll in TRICARE Prime if their sponsor is called to active duty for more than 30 days. If eligibility criteria are met, eligible family members may enroll in TRICARE Prime Remote for Active Duty Family Members. There are no enrollment fees or co-payments for family members, but enrollment forms must be completed, and MTFs or TRICARE Prime network providers must be used. Many RC families may have continuing relationships with providers who are not in the TRICARE Prime network. In these cases, enrolling in TRICARE Prime may not be the best choice—instead, using TRICARE Standard can be the most flexible option, even though beneficiaries may be required to pay a share of the cost of health care. If family members are eligible for the TRICARE Reserve Family Demonstration Project (see the next section), the TRICARE Standard deductible will be waived.

Members of the Selected Reserve and Individual Ready Reserve (IRR) and/or their families may enroll in the TRICARE Dental Program (TDP). RC members who are ordered to active duty for more than 30 consecutive days are eligible for military dental care, the same as ADSMs, and members are automatically disenrolled from the TDP if previously enrolled.

When RC members retire, they do not become eligible for TRICARE or space-available care in an MTF until they reach age 60 or are receiving retired pay. At that time, they and their family members may enroll in TRICARE Prime or they may use TRICARE Extra or TRICARE Standard. Retired RC members also become eligible for TRICARE For Life (TFL) when they become eligible for Medicare at age 65 and enroll in Medicare Part B. In addition, retired RC members and their spouses and dependent children are eligible for the TRICARE Retiree Dental Program (TRDP), regardless of the sponsor's age and whether the sponsor is receiving retired pay.

TRICARE Reserve Family Demonstration Project

The TRICARE Reserve Family Demonstration Project is effective for health care services received on or after September 14, 2001, and it is nationwide. Demonstration participants are limited to families of Reserve and National Guard members called to active duty for periods of more than 30 days in support of operations that result from the terrorist attacks of September 11, 2001, under Executive Order 13223, 10 U.S.C. 12302, 10 U.S.C. 12301(d), or 32 U.S.C. 502(f). Such operations include, for example, OPERATIONS ENDURING FREEDOM, NOBLE EAGLE, and IRAQI FREEDOM.

TRICARE Reserve Family Demonstration Project components include:

- Waiver of TRICARE Standard annual deductible
- Waiver of the TRICARE allowable charge under TRICARE Standard
- Waiver of nonavailability statement (NAS) requirement for nonemergency inpatient care

Temporary Reserve Health Care Benefits for 2004

The recently enacted Emergency Supplemental Appropriations Act and the National Defense Authorization Act for Fiscal Year 2004 authorized temporary health care benefits for TRICARE eligibility for eligible RC sponsors and family members.

TRICARE Management Activity (TMA) is working closely with Reserve Affairs and the uniformed services to implement these temporary benefits for the RC and their families. Please visit the TRICARE Web site at www.tricare.osd.mil for new information about these temporary benefits as the details are made available. Additionally, information about the benefits will be highlighted in provider newsletters, bulletins, and other educational materials in the future.

Department of Defense/ National Cancer Institute Demonstration Program

The DoD joined forces with the National Cancer Institute (NCI) through an interagency agreement, known as the DoD/NCI Cancer Clinical Trials Demonstration Project, to offer TRICARE beneficiaries and the health professionals who care for them the latest in both cancer preventive care and treatment. Under this agreement, beneficiaries can participate in NCI-sponsored cancer prevention and treatment studies as part of their TRICARE health care benefits.

The clinical trials can offer people at risk for cancer and people diagnosed with cancer some of the most promising advances in cancer research. For some TRICARE beneficiaries with cancer, the DoD/NCI Clinical Trials project offers choices when few treatment options exist. However, before patients and their doctors decide whether or not to participate in a clinical trial, there are many important questions to consider.

As a physician or health professional, you are dedicated to providing the latest, most effective medical care for your patients. If you care for patients with cancer or at risk for cancer, offering them an option to enroll in clinical trials sponsored by the NCI may give them access to the most promising advances in cancer research.

For more information visit www.tricare.osd.mil/cancertrials.

Program for Persons with Disabilities

The Program for Persons with Disabilities (PFPWD) provides financial assistance to reduce the effects of a qualifying condition. It is not a stand-alone program; subject to certain restrictions, it may be used concurrently with other TRICARE programs. The PFPWD is not an enrollment program. Only family members of active duty service members are eligible for the program. PFPWD serves persons with a moderate or severe mental retardation or a serious physical disability.

Active duty family members, or persons acting on their behalf, who apply for benefits under the PFPWD must show that the medical condition qualifies them for the program and that the requested benefits are necessary and appropriate.

All program benefits must be authorized in advance. Beneficiaries should contact a Humana Military PFPWD case manager for guidelines on the type of information required to establish the existence of a qualifying medical condition and to establish the need for the benefits requested.

The PFPWD will be replaced during 2004 by the new TRICARE Extended Care Health Option (ECHO). Information about TRICARE ECHO will be provided as the new program rolls out in the TRICARE West Region, and beneficiaries currently receiving PFPWD benefits will be contacted about the new TRICARE ECHO program. Please advise beneficiaries to visit the TRICARE Web site at www.tricare.osd.mil for additional information.

Supplemental Health Care Program

The Supplemental Health Care Program (SHCP) provides coverage for ADSMs (except those enrolled in TPR) and non-active duty individuals under certain conditions when referred to civilian providers for certain services or treatments. While the SHCP is also funded by the DoD, it is separate from TRICARE. Only the following individuals are eligible for the SHCP:

- ADSMs not assigned to a military treatment facility (MTF) and those enrolled in TPR
- ADSMs on travel status (e.g., leave, temporary assignment to duty, or permanent change of station)
- Navy or Marine Corps service members enrolled to deployable units and referred by the unit primary care manager (PCM) or other provider who is not an MTF PCM
- Reserve Component (RC) members on active duty
- National Guard members (line-of-duty care only, unless beneficiary is on active federal service)
- National Oceanic and Atmospheric Administration, U.S. Public Health Service, cadets or midshipmen, and eligible foreign military personnel

- Non-active duty beneficiaries—when an inpatient in an MTF, and referred to a civilian facility for a test or procedure unavailable in the MTF, provided the MTF maintains continuity of care over the inpatient and the beneficiary is not discharged from the MTF prior to the procedure
- Comprehensive Clinical Evaluation Program participants
- Dependent parents or parents-in-law with MTF approval

To verify patient eligibility for the SHCP, call Humana Military at 1-877-249-9179.

Civilian Care

When SHCP individuals need services that are not available at the MTF, the MTF physician issues a referral to a civilian provider. Care referred or authorized by the MTF and/or the Military Medical Support Office (MMSO) will be covered under the SHCP. SHCP individuals are not responsible for deductibles, cost-shares, or copayments.

Provider Responsibilities

Network providers are required to adhere to all contract requirements when treating SHCP individuals, including office and appointment access standards. Refer to the section titled "Important Provider Information" for more information about provider responsibilities.

Other Health Insurance and Third Party Liability

Humana Military will not apply other health insurance or third-party liability processing procedures to SHCP claims for outpatient active duty and non-TRICARE-eligible beneficiaries. These procedures will also not apply to all SHCP inpatient claims.

Claims Submission

Claims for the SHCP are processed and paid through PGBA. All TRICARE claims must be sent to the address below:

TRICARE South Region
Claims Department
P.O. Box 7031
Camden, SC 29020-7031

The same balance billing limitations applicable to TRICARE apply to the SHCP. For more information regarding balance billing, see the section titled "Important Provider Information."

For more information regarding SHCP, visit www.humana-military.com or call 1-877-249-9179.

Transitional Health Care Benefits

TRICARE offers options for those beneficiaries who are separating from active duty. These options are described below.

Continued Health Care Benefit Program

The Continued Health Care Benefit Program (CHCBP) is intended to provide transitional benefits for a specified period of time (18–36 months) to former service members and their families, some un-remarried former spouses, and emancipated children (living on their own) who enroll and pay quarterly premiums. The benefits available under CHCBP are similar to TRICARE Standard, and although it is not part of TRICARE Standard, it operates under most of the same rules. The quarterly premiums for the coverage are $933 for one person and $1,996 for a family. To receive coverage under CHCBP, eligible persons must enroll within 60 days after separating from active duty or from losing their eligibility for military health care. The DoD has contracted with Healthcare Services, Inc. (Humana Military) to help administer the CHCBP. Beneficiaries may contact Humana Military in writing or by phone for any information regarding CHCBP at the following address or phone number:

Humana Military Healthcare Services, Inc.
Attn: CHCBP
P.O. Box 740072
Louisville, KY 40202
1-800-444-5445

Transitional Assistance Management Program

The Transitional Assistance Management Program (TAMP) allows that certain uniformed service and family members may be eligible for transitional health care benefits when the sponsor separates from active duty service. Service member categories include:

- A member who is involuntarily separated from active duty
- A Reserve Component (RC) member who is separated from active duty and who was called up or ordered in support of a contingency operation for an active duty period of more than 30 days
- A member who is separated from active duty and is involuntarily retained in support of a contingency operation
- A member who is separated from active duty following a voluntary agreement to stay on active duty for a period of less than one year in support of a contingency mission

Notes

Notes

A summary of TRICARE-covered services including limitations and exclusions

Medical Coverage

TRICARE covers most inpatient and outpatient care that is medically necessary and considered proven. However, there are special rules or limits on certain types of care, while other types of care are not covered at all. Some military treatment facilities (MTFs) may offer services, procedures, or benefits that are not necessarily covered under TRICARE. Beneficiaries should contact their local MTF for more information.

The following charts and information summarize TRICARE-covered and non-covered services.

Please note that TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) offer coverage similar to TRICARE Prime. For additional information or specific questions about covered services, contact Humana Military's TRICARE Service Line at 1-800-444-5445 or review the TRICARE Policy Manual, TRICARE Reimbursement Manual, and TRICARE Operations Manual online at www.tricare.osd.mil.

Outpatient Services Outside of a Military Treatment Facility

Outpatient services received in an MTF are at no cost to the beneficiary. For the charts on the following pages, "ADFM" is the active duty family member responsibility.

Services Covered	TRICARE Prime**	TRICARE Extra*	TRICARE Standard*
Ancillary Services Certain diagnostic radiology and ultrasound (70000-76999); diagnostic nuclear medicine (78000-78999); pathology and laboratory services (80000-89399); and cardiovascular studies (93000-93350)	Per visit: **ADFM:** No copayment **Retirees and others:** No copayment	**ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** 25% of the maximum allowable charge
Ambulance Services When medically necessary and when needed for a medical condition that is covered by TRICARE	Per occurrence: **ADFM:** No copayment **Retirees and others:** $20 copayment	*Same as above*	*Same as above*
Ambulatory Surgery (Same Day)[1] When surgery is conducted at a hospital-based or freestanding ambulatory surgical center that is TRICARE-certified TRICARE Prime Retirees and others—copayment is applied to the ambulatory surgical facility only.	Per occurrence: **ADFM:** No copayment **Retirees and others:** $25 copayment	**ADFM:** $25 copayment **Retirees and others:** Professional—20% of contracted reimbursement Facility—20% of contracted reimbursement	**ADFM:** $25 copayment **Retirees and others:** Professional—25% of the maximum allowable charge Facility—25% of the group rate or 25% of billed charges; whichever is less

**Cost-share is applied after deductible has been satisfied.*

***Benefits under TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are similar to TRICARE Prime.*

1. TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.

2. If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.

3. Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.

Outpatient Services Outside of a Military Treatment Facility (continued)

Services Covered	TRICARE Prime**	TRICARE Extra*	TRICARE Standard*
Durable Medical Equipment (DME), Prosthetic Devices and Medical Supplies (Prescribed by a Physician)[1][3] For DME, prosthetic devices, and medical supplies, care is subject to TRICARE policy after an office or home health visit when medically necessary and a covered benefit.	**ADFM:** No copayment **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** 25% of the maximum allowable charge
Emergency Services[1] Emergency care obtained on an outpatient basis, both network and non-network, in or out of the region	Per visit: **ADFM:** No copayment **Retirees and others:** $30 copayment	*Same as above*	*Same as above*
Eye Examinations One routine examination per year for active duty family members.	**ADFM:** No copayment **Retirees and others:** Not covered	**ADFM:** 15% of contracted reimbursement **Retirees and others:** Not covered	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** Not covered
Individual Provider Services[1] Office visits; outpatient office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services, e.g., physical therapy, speech pathology services, and occupational therapy; medical supplies used within the office, including casts, dressings, and splints	Per visit: **ADFM:** No copayment **Retirees and others:** $12 copayment	**ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** 25% of the maximum allowable charge
Immunizations for Required Overseas Travel Immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations	Per Visit: **ADFM:** No copayment **Retirees and others:** Not covered	**ADFM:** 15% of contracted reimbursement **Retirees and others:** Not covered	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** Not covered
Laboratory and X-Ray Services (provided as part of an office visit) [1][2] TRICARE Prime Retirees and others do not have an additional copayment if these services are provided as part of an office visit.	Per visit: **ADFM:** No copayment **Retirees and others:** $12 copayment	**ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	**ADFM:** 20% of the maximum allowable charge **Retirees and others:** 25% of the maximum allowable charge

**Cost-share is applied after deductible has been satisfied.*

***Benefits under TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are similar to TRICARE Prime.*

1. TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.

2. If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.

3. Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.

Home Health Care

Same as the Medicare home health care benefit, providing a maximum of 28 hours per week part time, or 35 hours per week intermittent, skilled nursing care and physical, speech, and occupational therapy. All care must be provided by a participating home health care agency.

Services provided by an authorized home health care agency that are covered under the Home Health Prospective Payment System (PPS) do not have a beneficiary copayment or cost-share. Other services provided outside of the PPS may be subject to a copayment or cost-share.

Inpatient Services (MTF and Civilian Facility)*

Services Covered	TRICARE Prime**	TRICARE Extra	TRICARE Standard
Hospitalization[1][2][3] Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and surgical services; meals, including special diets; drugs and medications while an inpatient; operating and recovery room; anesthesia; laboratory tests; X-rays and other radiology services; necessary medical supplies and appliances; and blood and blood products. Unlimited services, as medically necessary.	**ADFM:** MTF: No copayment Civilian: No copayment **Retirees and others:** MTF: $13.32 per day Civilian: $11 per day or $25 minimum charge per admission, whichever is greater. (No separate copayment for separately billed professional charges. Catastrophic Cap protection limits do apply.)	**ADFM:** MTF: $13.32 per day Civilian: $13.32 per day or $25 minimum charge per admission, whichever is greater. **Retirees and others:** MTF: $13.32 per day Civilian: $250 per day or 25% cost-share of the total contracted reimbursement for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges based on the contracted reimbursement.	**ADFM:** MTF: $13.32 per day Civilian care: $13.32 per day or $25 minimum charge per admission, whichever is greater. **Retirees and others:** MTF: $13.32 per day Civilian: $459 per day or 25% cost-share of billed charges, whichever is less, plus 25% cost-share of the maximum allowable charge for separately billed professional charges.
Maternity[1][2] Hospital and professional services (prenatal, postnatal). Unlimited services, as medically necessary.	*Same as above*	*Same as above*	*Same as above*
Skilled Nursing Facility (SNF) Care[1][4] Semiprivate room; regular nursing services; meals, including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances. Unlimited services, as medically necessary.	*Same as above*	**ADFM:** MTF: $13.32 per day Civilian: $13.32 per day or $25 minimum charge per admission, whichever is greater. **Retirees and others:** MTF: $13.32 per day Civilian: Lesser of $250 per day or 20% of the negotiated fee for institutional services, plus 20% of the negotiated professional fee.	**ADFM:** $25 per admission or $13.32 per day, whichever is greater. **Retirees and others:** 25% cost-share of allowed charges, plus 25% cost-share of the maximum allowable charge for separately billed professional charges.

** Cost-shares reflecting a dollar amount are subject to change (i.e. $13.32 per day).*

*** Benefits under TPR and TPRADFM are similar to TRICARE Prime.*

1. Cost-share and daily inpatient charges are subject to change at the beginning of each fiscal year (October 1–September 30).

2. TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.

3. TRICARE Standard cost-share for retirees may vary depending on type of treatment or type of hospital.

4. Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.

Hospice Care

Hospice care is available, in lieu of other TRICARE benefits, to provide palliative care to individuals with prognoses of less than six months to live if the terminal illness runs its normal course. Hospice care must be provided by a Medicare-approved program and may include: physician services, nursing care, counseling, inpatient respite care, medical supplies, medications, medical social services, home health aide services, physical and occupational services, speech and language pathology, and short-term acute patient care related to terminal diagnosis.

Note: The individual hospice may charge a cost-share for medications, biologicals, and/or inpatient respite care.

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Clinical Preventive Examinations Comprehensive-health-promotion and disease-prevention exams for ages 24 months and older Examinations can include: blood pressure tests; clinical breast exams (high-risk women age 39 and under; annually for all women over 40); pelvic exams (same guideline as Pap smears and should be administered during same visit); clinical testicular exams (annually for high-risk men 13-39); digital rectal exams (annually for high-risk men 40-49; and all men over 50); Prostate Specific Antigen (annually for high-risk men 40-49; men with history of vasectomy at least 20 years previous or at age 40 and over; and all men over 50); oral cavity exams; thyroid palpations; school enrollment physicals ages 5-11 years ***Note**: Annual sports physicals are not a covered benefit under TRICARE.*	No copayment *Clinical preventive services are an enhanced benefit under TRICARE Prime.*	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.
Eye Examinations Clinical preventive service eye exams vary by TRICARE program option (see columns for details of coverage for children and adults). ***Note:** In addition to the clinical preventive service eye exams, ADFMs can receive annual eye exams under normal TRICARE outpatient benefits.* Except for active duty service members (ADSMs), lenses or eyeglasses are only cost-shared for treatment of infantile glaucoma, keratoconus, dry eyes, and irregularities in the shape of the eye.	***For Infants:*** **No copayment** • One eye and vision screening by the beneficiary's PCM during routine exam at birth and 6 months of age. Exam to include screening for visual acuity, ocular alignment, and red reflex along with external examination for ocular abnormalities. ***For Adults and Children Age 3 and over:*** **No copayment** • One comprehensive eye exam by a specialist (ophthalmologist or optometrist) including screening for visual acuity and glaucoma every two years. • Diabetic patients at any age are covered for one comprehensive eye exam yearly.	***For Children:*** **Covered under Well-Child Care benefit.** Applicable cost-share and deductible apply. • One eye and vision screening by a TRICARE network provider during routine exam at birth and 6 months of age. • Two comprehensive eye exams by specialist (ophthalmologist or optometrist) for amblyopia (vision loss) and strabismus (cross eye) between 3-6 years of age. ***For Adults:*** Not covered	***For Children:*** **Covered under Well-Child Care benefit.** Applicable cost-share and deductible apply. • One eye and vision screening by a TRICARE network provider during routine exam at birth and 6 months of age. • Two comprehensive eye exams by specialist (ophthalmologist or optometrist) for amblyopia (vision loss) and strabismus (cross eye) between 3-6 years of age. ***For Adults:*** Not covered

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

Clinical Preventive Services (continued)

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Immunizations Age appropriate doses of vaccines recommended and adopted by the Center for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). Refer to CDC's homepage (www.cdc.gov) for a current schedule of recommended vaccines. *Immunizations for Overseas Travel: See information listed in the Outpatient Services Outside of the MTF section of these charts.*	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.
Patient and Parent Education or Counseling Services The following education or counseling services are covered when included as part of an office visit: dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; accident and injury prevention; promoting dental health; stress, bereavement, and suicide risk assessment.	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.
Periodic Screening Examinations Beneficiaries will be offered age- and gender-appropriate screening tests for the early detection of disease and/or disease risk factors, including: **Cancer Screening:** Annual screening mammograms for women over the age of 39, (for high-risk baseline at 35 years, then annually); Pap smears (see below); proctosigmoidoscopy or sigmoidoscopy (once every 3-5 years beginning at age 50); colonoscopy (every 2 years beginning at age 25 or 5 years younger than the earliest age of diagnosis for colon rectal cancer, whichever is earlier, and then annually after age 40 for individuals with hereditary non-polyposis colon rectal cancer syndrome. Individuals with familial risk of sporadic colon rectal cancer (i.e. individuals with first degree relatives with sporadic colon rectal cancer or adenomas before the age of 60 or multiple first degree relatives with colon rectal cancer or adenomas) may receive a colonoscopy every 3 to 5 years beginning at age 10 years earlier than the youngest affected relative), and fecal occult blood testing (annually age 50 and above); skin cancer exams (for high-risk individuals with family history or increased exposure to sunlight)	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

Clinical Preventive Services (continued)

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Routine Pap Smears: Annually starting at age 18 (or younger if sexually active) until three consecutive satisfactorily normal annual examinations. Frequency may be less often at the discretion of the patient and the clinician, but not less than every three years. **Infectious Disease Screening:** Screening for Hepatitis B, Rubella antibodies, and HIV and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, Hepatitis A&B, meningococcal meningitis, and tuberculosis **Cardiovascular:** Cholesterol (once every 5 years beginning at age 18) and blood pressure (children: annually between ages 3-6 and every 2 years thereafter; adults: minimum every 2 years) **Hearing:** Preventive hearing screenings for all high-risk neonates as defined by the Joint Committee on Infant Hearing. A newborn audiology screening should be performed on high-risk newborns prior to hospital discharge or within the first three months. Evaluative hearing tests may be performed at other ages during routine exams. **Other:** Assessment of risk for lead exposure by structured questionnaire (during each Well-Child Care visit from 6 months to 6 years); blood lead test for all children determined to be high-risk	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.
Well-Child Care Well-Child Care (birth to 6 years) includes routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight, and head circumference; routine immunizations; and developmental and behavioral appraisal in accordance with the American Academy of Pediatrics (AAP) and CDC guidelines.	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.

**TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.*

U.S. Preventive Services Task Force

The U.S. Preventive Services Task Force and other major authorities recommend that a clinical preventive examination be used for early detection of disease. This provides prompt treatment and encourages healthy lifestyles. A TRICARE-covered clinical preventive examination is performed periodically and includes the following:

- Risk assessment
- Physical examination
- Laboratory tests
- X-rays
- Risk-specific counseling allowing for prevention, early detection, and treatment of diseases before they manifest themselves as major health problems

A network provider must perform a clinical preventive examination for a TRICARE Prime beneficiary. A TRICARE Standard beneficiary may have clinical preventive examinations performed by a network or certified non-network provider. As depicted in the chart on the previous page, TRICARE Extra and TRICARE Standard beneficiaries do not have the same clinical preventive services as TRICARE Prime beneficiaries.

Routine Physical Examinations

TRICARE benefits are different for routine physical examinations than for clinical preventive examinations. Routine physical examinations are not a TRICARE-covered benefit. TRICARE considers a routine physical examination to be an evaluation of the general health of adults and children conducted in the absence of a presenting complaint or other indication of illness or injury.

When required by the uniformed services, claims may be covered for physical examinations provided for family members traveling outside of the U.S. as a result of their sponsoring active duty service member's assignment. Such claims must be accompanied by documentation indicating the ADSM's overseas assignment.

Emergency and Urgent Care

Urgent Care

Urgent care services are medically necessary services which are required for illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop into such a threat if treatment is delayed longer than 24 hours. An urgent care condition could be a sprain, sore throat, or rising temperature.

Emergency Services

In the event of a life-, limb-, or eyesight-threatening emergency, the beneficiary should go, or be taken to, the nearest appropriate medical facility for care. In all emergency situations, the TRICARE Prime beneficiary must notify his/her PCM or Humana Military of any emergency admission within 24 hours so that ongoing care can be coordinated.

Emergency care is covered for medical, maternity, or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition existed or that the absence of medical attention would result in a threat to life, limb, or sight, or that the person may be a danger to self or others and requires immediate medical treatment or manifests painful symptoms requiring immediate palliative effort to relieve suffering. This includes situations where a beneficiary arrives at the emergency room with severe pain. In the case of a pregnant woman, the danger to the health of the woman or her unborn child should be considered.

Limitations and Exclusions

Following is a list of medical/surgical services generally not covered under TRICARE. The items here are not intended to be all-inclusive. Contact Humana Military or visit their Web site for more information.

Services or Procedures with Significant Limitations

Abortions—Abortions are only covered when the mother's life is in danger. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.

Cardiac and Pulmonary Rehabilitation—Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.

Chiropractic Care—Coverage is limited to active duty service members and is only available at specific military treatment facilities under the Chiropractic Care Program. Visit the TRICARE Web site at www.tricare.osd.mil/chiropractic for more information.

Cosmetic, Plastic, or Reconstructive Surgery—Only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement after cancer surgery, or breast reconstruction after cancer surgery.

Cranial Orthotic Device or Molding Helmet—Cranial orthotic devices are excluded for treatment of nonsynostic positional plagiocephaly.

Dental Care and Dental X-Rays—Both are covered only for adjunctive dental care.

Dental Anesthesia and Facility Charges—Covered only to safeguard a patient's life.

Education and Training—Education and training are only covered under the PFPWD and diabetic outpatient self-management training services (HCPCS G0108 and G0109 codes must be accompanied with a "Certificate of Recognition" from the ADA.)

Eyeglasses or Contact Lenses—Both are covered under limited circumstances, such as corneal lens removal.

Food, Food Substitutes or Supplements, or Vitamins Outside of a Hospital Setting—Covered only for home enteral or parenteral nutrition therapy, such as prescribed for cancer patients.

Gastric Bypass—To be covered, you must be 100 pounds over ideal body weight and have a co-morbidity or 200 percent of ideal body weight with no co-morbidity.

Genetic Testing—Genetic testing is only covered under certain conditions.

Hearing Aids—Hearing aids are covered under the PFPWD.

Exclusions

The following services are excluded under any circumstance:

- Acupuncture
- Artificial insemination
- Autopsy services or post-mortem examinations
- Birth control (non-prescription)
- Bone marrow transplants for treatment of ovarian cancer
- Camps
- Care or supplies furnished or prescribed by an immediate family member
- Naturopaths
- Diagnostic admission
- Experimental or unproven procedures
- Foot care (routine)
- Laser/LASIK/Refractive corneal surgery
- Learning disabilities

An explanation of covered behavioral services and how to manage and document care

Behavioral Health Care Services

This section will assist you with specific behavioral health aspects of the TRICARE program. ValueOptions provider relations representatives are available to answer non-clinical questions, address concerns, or accept requests for additional information. To reach a provider relations representative, call 1-800-700-8646 between the hours of 8 a.m. and 6 p.m. Eastern Standard time.

Provider Responsibilities

All TRICARE Prime beneficiaries are assigned a primary care manager (PCM). Those TRICARE Prime beneficiaries who have a PCM at a military treatment facility (MTF) must obtain pre-authorization from the MTF for all inpatient mental health and substance use treatment. A TRICARE Prime beneficiary is required to check with his or her PCM or health care finder to determine if a referral or authorization is required before obtaining outpatient behavioral health care services.

PCMs seeking behavioral health or substance use information should contact ValueOptions at 1-800-700-8646. MTF PCMs may alternatively submit a Form 2161 by fax to 1-904-996-2060.

The PCM is responsible for the coordination of all care. To ensure coordination of care, when a TRICARE Prime beneficiary receives behavioral health or substance use care, TRICARE requires the rendering provider submit a consult report to the PCM within 10 working days of the specialty encounter. Emergency consult feedback is requested within 24 hours. If the beneficiary refuses to sign a medical release for the consult report, the provider is obligated to inform ValueOptions of the beneficiary's decision within the time period described above.

TRICARE beneficiaries are encouraged to receive behavioral health care from an MTF; however, access may be limited due to space-availability issues or the MTF's ability to render the care needed. When a service is not available at an MTF, beneficiaries will be referred to a ValueOptions network provider. Referrals to network providers are based on a number of factors, including:

- Geographic location
- Specialty
- Preferred gender of the provider
- Preferred discipline of the provider

Office and Appointment Access Standards

By signing a TRICARE contract, network providers are obligated to adhere to all contract requirements. One of the requirements is to meet all office and appointment access standards. Maximum wait times for appointments are:

- Wait time for specialty care appointments will be based on the nature of the care required, but will not exceed four weeks. Behavioral health care is considered a specialty. The primary care manager determines the level of urgency.
- Office waiting times for nonemergency situations will not exceed 30 minutes. Providers who are not able to adhere should notify the patient and offer to reschedule.

Balance Billing

Network providers may only bill TRICARE beneficiaries for applicable deductible, copayment, or cost-share amounts, but may not bill for charges that exceed contractually allowed payment rates. Because network providers have contractually agreed to adhere to these provisions, TRICARE beneficiaries will be referred first to a network provider.

Non-network providers who do accept assignment (participating providers) are limited to collecting the TRICARE allowable charge. If the billed charge is less than the allowable charge, the billed charge becomes the allowable charge. This only applies to services covered by TRICARE.

When providers do not accept assignment on a claim, non-network providers may collect applicable deductibles and/or cost-shares and any outstanding amounts up to 15 percent above the

TRICARE allowable charge (shown on the remittance advice) from a TRICARE beneficiary. If the billed charge is less than the TRICARE-allowed amount, the billed charge becomes the billable amount to the beneficiary. TRICARE discourages military families from using non-network nonparticipating providers.

This applies only to services covered by TRICARE. TRICARE's balance-billing limit also applies when other health insurance (OHI) is involved. Providers are limited to collecting the amount described above. Generally, the OHI payment, when combined with TRICARE's payment, represents the total amount a provider can bill.

Non-compliance with these balance-billing requirements by any TRICARE provider may affect that provider's TRICARE and/or Medicare status. Additional information on this topic may be obtained by visiting www.tricare.osd.mil.

Release of Medical Records

The provider shall request each beneficiary sign a release of information, to include all ancillary services, in order to release medical information. The records of beneficiaries shall be maintained in accordance with all state and federal regulations.

Providers are allowed under the Health Insurance Portability and Accountability Act (HIPAA) to release information regarding treatment, payment, and operations to ValueOptions without the beneficiary's authorization. This includes record requests for validation audits conducted by the National Quality Monitoring Contractor (NQMC), as well as ValueOptions Quality and Utilization Management activities.

Waivers of Non-covered Services

A network provider can utilize the waiver of non-covered services when the beneficiary is properly informed, in advance, that TRICARE does not cover a particular service and he or she agrees in writing to be financially responsible. TRICARE beneficiaries must be properly informed in advance and in writing of specific services or procedures that are not covered under TRICARE before they are provided. However, if the provider does not obtain a legal signed waiver, and the care is not authorized, the provider is expected to accept full financial liability for the cost of the care. In addition, the waiver signed by a beneficiary after the care is rendered is not valid under TRICARE regulations. For the beneficiary to be considered fully informed, TRICARE regulations require that:

- The agreement is documented prior to the specific non-covered services being rendered
- The agreement is in writing
- The specific treatment, rendering provider, cost of services, and date(s) of service are documented
- General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or not allowable

Providers should maintain copies of the waiver in their office and fully inform beneficiaries in advance when specific services or procedures are not covered.

Nonavailability Statements for Inpatient Care

A nonavailability statement (NAS) is a certification from an MTF stating that it cannot provide a specific required service at a particular time to a non-enrolled beneficiary. An NAS is required for all non-emergent mental health admissions. The need for an NAS for non-emergent inpatient mental health admissions applies only to beneficiaries who use TRICARE Extra or TRICARE Standard, and are not Medicare-eligible or have no other health insurance primary to TRICARE. If an NAS is required, cost-sharing (processing of claims) for services will not occur until the NAS is issued. If a beneficiary is uncertain an NAS is required for a behavioral health admission, they can contact a ValueOptions representative or check with the beneficiary counseling and assistance coordinator (BCAC) at the local MTF. An NAS does not take the place of an authorization for those services requiring pre-authorization.

Covered Behavioral Health Services

Outpatient Services

Beneficiaries must check with their PCM or the HCF before self-referring for mental health care. If the provider is a licensed mental health counselor (LMHC), a licensed professional counselor (LPC), or a pastoral counselor, a physician referral is required prior to the initial evaluation, and oversight must continue throughout the course of therapy in order to be reimbursed by TRICARE. This is a TRICARE program requirement that cannot be altered or waived.

To obtain pre-authorization for specialized outpatient services, the provider must submit a request by fax at 1-904-996-2059 or mail to the address below. A utilization specialist will review the request to determine whether the requested services are a TRICARE benefit and meet medical necessity.

ValueOptions
P. O. Box 551188
Jacksonville, FL 32255-1188

Each provider will be allowed one outpatient psychiatric diagnostic interview session (90801 session) per beneficiary per year without authorization; however, a referral may be required. If a provider needs more than one 90801 session within the same benefit period, authorization must be requested using the "Outpatient Treatment Request" (OTR) form.

Outpatient Psychotherapy

Outpatient psychotherapy is a TRICARE-authorized benefit when it is determined to be medically or psychologically necessary for treatment of a behavioral health disorder. The following services are available for outpatient psychotherapy:

- Individual psychotherapy
- Group or conjoint therapy (up to 90 minutes)
- Crisis intervention (up to 75-80 minutes)
- Collateral visits
- Family therapy (up to 90 minutes)
- Psychoanalysis

Note: Psychoanalysis, electroconvulsive therapy (ECT), crisis intervention, and psychological testing require separate authorizations.

The following frequency limitations apply to outpatient psychotherapy:

The TRICARE benefit limit for routine outpatient therapy is up to two times per calendar week (Sunday through Saturday) per beneficiary. Pre-authorization requirements for therapy sessions up to the benefit limit are listed below. The service(s) must be provided by a TRICARE-certified provider(s). If a beneficiary needs to be seen more often, the provider(s) must request pre-authorization. Due to this requirement, it is very important that you, the provider, are aware of any other providers the beneficiary is seeing for therapy and to contact ValueOptions for authorization, if needed. Medication management (CPT-4 code 90862) is not subject to these frequency limits and does not require pre-authorization.

- Two psychotherapy sessions may not be combined (e.g., 30 minutes on one day may not be added to 20 minutes on another day and counted as one session) to circumvent the frequency limitation criteria.
- When multiple sessions of the same type are conducted on the same day (e.g., two individual sessions or two group sessions), only one session is reimbursed.

Specific pre-authorization will be required for any services requested above the frequency limitations. Pre-authorization can be requested by submitting an OTR via fax, telephone, or mail.

Psychological and Neuropsychological Testing

Psychological and neuropsychological testing and assessment are generally limited to six hours in a fiscal year; however, additional hours may be approved in special circumstances on a case-by-case basis. The testing must be medically

necessary and performed in conjunction with otherwise-covered psychotherapy. Medical necessity must be established prior to the actual testing (i.e., there must be either a diagnosis or provisional diagnosis of a behavioral health disorder, and the testing must be appropriate for the diagnosis).

Psychological and neuropsychological testing always require pre-authorization, regardless of the setting (inpatient or outpatient). A "Pre-authorization for Psychological Testing" form must be submitted for authorization. When completing the form, a provider may request an initial evaluation in conjunction with testing. The following psychological and neuropsychological tests are not covered under TRICARE:

- Reitan-Indiana battery when administered to a beneficiary under age five
- Any self-administered tests to beneficiaries under age 13
- Assessment for academic placement, including all psychological testing related to educational programs, issues, or deficiencies
- Testing to determine a learning disability, if the primary or sole basis for the testing is to assess for a learning disability
- Testing in conjunction with child custody disputes
- Testing in conjunction with job placement
- General screening (in the absence of specific symptoms of a covered behavioral health disorder) to determine if individuals being tested are suffering from a behavioral health disorder
- Teacher or parental referrals for psychological testing
- Diagnosed specific learning disorders or learning disabilities encompassing a reading disorder (e.g., dyslexia), mathematics disorder, disorder of written expression, or learning disorder not otherwise specified

Medication Management

Medication management is covered when provided as an independent procedure and rendered by a TRICARE-authorized provider practicing within the scope of their license. Medication management (procedure code 90862) does not require pre-authorization.

Note: When a provider is performing medication management along with therapy (procedure codes 90805, 90807, 90809, etc.), pre-authorization requirements, as described in the Outpatient Psychotherapy section, apply.

Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) is a TRICARE-authorized benefit when determined to be medically necessary. Providers must request pre-authorization for outpatient ECT. A "Request for ECT" form must be submitted to ValueOptions for authorization.

Inpatient Services

Note: TRICARE Prime beneficiaries enrolled at an MTF, must have initial authorization for services from the MTF.

Acute Inpatient Care

The purpose of acute inpatient care is to stabilize a life-threatening or severely disabling behavioral health condition. TRICARE defines a psychiatric emergency admission as "an admission when, based on a psychiatric evaluation performed by a physician (or other qualified behavioral health care provider with hospital admission authority), the beneficiary is at immediate risk of serious harm to self or others as a result of a behavioral health disorder and requires immediate continuous skilled observation at the acute level of care."

In a life-threatening situation, the provider should direct the beneficiary to the closest appropriate health care facility. If an MTF is geographically available, referral to the MTF emergency room is appropriate. The beneficiary's age at the time of admission determines the actual number of benefit days per fiscal year that can be authorized for acute inpatient care. The range is as follows:

- 30 days for beneficiaries 19 and older

or

- 45 days for beneficiaries 18 and younger

An inpatient admission for substance abuse detoxification and rehabilitation counts toward the 30-/45-day limit for inpatient behavioral health services, regardless of whether the beneficiary is admitted to a general hospital or freestanding substance use disorder rehabilitation facility (SUDRF).

Authorization is required for all behavioral health admissions without exception. Pre-authorization is required for all non-emergent admissions. Admissions resulting from a bona fide psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission. ValueOptions will conduct a concurrent review for continuation of inpatient mental health services and authorize, as appropriate, additional days.

Inpatient Psychotherapy

Inpatient psychotherapy is limited to five sessions of any kind of psychotherapy per calendar week (Sunday through Saturday), unless medical review of the overall treatment plan for medical necessity and appropriateness is conducted.

Note: Facilities with all-inclusive contracts that include psychotherapy will not receive a separate payment for inpatient psychotherapy.

All facilities, whether hospital-based or freestanding, must adhere to the balance billing, release of medical records, and waivers of non-covered services provisions outlined in the Provider Responsibilities section of this chapter. Please refer to this section for guidelines.

Alcoholism and Other Substance Use Disorders

Treatment includes the following:

Inpatient Hospital Care

TRICARE helps pay for up to seven days of detoxification in a TRICARE-certified substance use disorder rehabilitation facility (SUDRF), as medically necessary. Hospital care may be needed when the patient suffers from delirium, confusion, trauma, unconsciousness, or malnutrition. The seven-day detoxification is included in the maximum of 30 or 45 days (depending on the patient's age) of inpatient mental health care allowed per fiscal year. This seven-day period does not count toward the 21 days of rehabilitation mentioned below.

Substance Use Rehabilitation Stays

In addition to the seven-day detoxification period mentioned above, TRICARE helps pay for up to 21 days of rehabilitation (this 21-day rehabilitation is included in the 30 or 45 days of inpatient mental health care allowed per fiscal year, but beneficiaries are limited to 21 days per 365-day period and three treatments during the person's life). Rehabilitation stays are covered only in a hospital or special treatment center whose alcohol or other SUDRF has entered into a participation agreement with TRICARE and has been identified as a TRICARE-certified facility. Treatment for alcoholism or other substance use disorders includes "partial hospitalization" in a TRICARE-certified SUDRF. Partial hospitalization is treatment that offers at least three hours a day, five days a week at the facility (the treatment may also occur during weekends or evenings). TRICARE shares the cost of this treatment up to 21 days at a predetermined, all-inclusive *per diem* rate as medically necessary. The 21-day rehabilitation limit includes the inpatient and partial hospitalization program days.

Outpatient Care for Alcoholism or Other Substance Use Disorders

TRICARE provides coverage for up to 60 facility-based, group therapy visits over the course of a "benefit year," beginning the first day of the rehabilitation phase of treatment. Family therapy is covered for up to 15 visits per year, beginning the first day of therapy.

Waivers to the limits on care can be granted, in special circumstances, if the continued care meets certain requirements. This is true of both inpatient care and partial hospitalization.

Residential Treatment Centers

Residential Treatment Centers (RTCs) provide treatment for adolescents (up to age 21) who require behavioral health care due to a serious behavioral health disorder. Children who only have disciplinary problems do not qualify for

treatment in an RTC setting. All RTCs must be TRICARE-certified by the National Quality Monitoring Contractor (NQMC) to provide residential treatment to TRICARE-eligible beneficiaries. The specific duration limit is a maximum of 150 days in a fiscal year or for a single admission, as medically necessary. These limits are subject to waiver in special cases.

Pre-authorization

A pre-authorization is always required before a beneficiary is admitted to an RTC. Documentation must be submitted to support each request. A psychiatrist or other physician must recommend that the child be admitted to the RTC, and a psychiatrist or clinical psychologist must direct the development of a treatment plan. The behavioral health disorder must meet clinical review criteria before admission can be authorized. In addition, concurrent reviews are conducted during the course of the RTC stay.

Reimbursement

TRICARE reimbursement for RTC care is an all-inclusive per diem rate. There are only two charges considered outside the all-inclusive RTC rate defined below:

- Geographically distant family therapy—The family therapist may bill and be reimbursed separately from the RTC if the therapy is provided to one or both of the child's parents residing a minimum of 250 miles from the RTC.
- RTC educational services—Educational services will be covered only in cases when appropriate education is not available from or not payable by, local, state, or federal governments. TRICARE is always the payer of last resort. For network providers, this coverage limitation applies only if educational services are not part of the contracted per diem rate.

Psychiatric Partial Hospitalization Programs

A psychiatric partial hospitalization program (PHP) provides an appropriate setting for crisis stabilization or treatment of partially stabilized behavioral health disorders. It also serves as a transition from an inpatient program when medically necessary. All psychiatric PHPs must be TRICARE-certified by the NQMC, in order to provide partial hospitalization care to TRICARE-eligible beneficiaries. Additionally, psychiatric PHP facilities must be capable of providing an interdisciplinary program of medically therapeutic services at least three hours per day, up to five days per week. This can include day, evening, or weekend treatment.

The TRICARE benefit for psychiatric PHP is limited to a maximum of 60 treatment days (whether a full- or half-day program) in a fiscal year or for any single admission. The limit may be waived in special cases if the waiver request is determined to be medically necessary and meets TRICARE Policy requirements. The 60 PHP treatment days are not offset by, nor counted toward, the inpatient limit of 30 days for beneficiaries aged 19 and older or 45 days for beneficiaries aged 18 and younger. Substance use partial hospitalization days will count toward the maximum 60 psychiatric partial hospitalization days.

Pre-authorization

A pre-authorization is required for all PHPs, without exception. The facility must submit sufficient documentation to support the services being requested. The admission will not meet criteria unless the patient has been personally evaluated, prior to the admission, by a physician or other health care professional with admitting privileges. Concurrent reviews are conducted during the course of the stay.

Reimbursement

Psychological testing conducted while a beneficiary is in an approved PHP will be considered included in the facility's per diem rate. PHP care must be billed on a UB-92.

- Revenue Code 912—Partial Hospitalization, all-inclusive per diem payment of non-substance abuse PHPs, three to five hours (half day)
- Revenue Code 913—Partial Hospitalization, all-inclusive per diem payment of non-substance abuse PHPs, six or more hours (full day)

ADFM represents the active duty family member responsibility.

Services Covered	TRICARE Prime	TRICARE Extra	TRICARE Standard
Outpatient Behavioral Health[1][5] Outpatient psychotherapy is limited to a maximum of two psychotherapy sessions per week in any combination of individual, family, collateral, or group sessions.	Individual & Family Therapy: **ADFM:** No copayment **Retirees and others:** $25 copayment Group Therapy: **ADFM:** No copayment **Retirees and others:** $17 copayment	Cost-share after deductible has been satisfied: **ADFM:** 15% of contracted reimbursement **Retirees and others:** 20% of contracted reimbursement	Cost-share after deductible has been satisfied: **ADFM:** 20% of the TRICARE-allowed amount **Retirees and others:** 25% of the TRICARE-allowed amount
Medication Management No prior authorization is required. (CPT code 90862)	**ADFM:** No copayment **Retirees and others:** $12 copayment	*Same as above*	*Same as above*
Hospitalization for Mental Illness[1][2][3][4] Up to 30 days per fiscal year (October 1–September 30) for age 19 and over; up to 45 days per fiscal year for age 18 and under. The Residential Treatment Center benefit is up to 150 days per fiscal year for children and adolescents (as medically or psychologically necessary).	**ADFM:** No copayment **Retirees and others:** $40 per day (No copayment for separately billed professional charges.)	**ADFM:** $20 per day ($25 minimum charge) **Retirees and others:** 20% cost-share of contracted reimbursement for institutional services, plus 20% cost-share of separately billed professional charges, based on contracted reimbursement.	**ADFM:** $20 per day ($25 minimum charge) **Retirees and others:** 25% cost-share of allowable charges for separately billed professional charges, plus, one of the following: Inpatient High Volume Hospital: 25% hospital specific per diem Inpatient Low Volume Hospital: Lesser of $164 per day or 25% hospital specific per diem RTC: 25% of the TRICARE-allowed amount Partial Hospitalization: 25% of the TRICARE-allowed amount
Substance Use Treatment (Inpatient Partial Hospital Program)[1][2][3][4] Up to seven days for detoxification and up to 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward inpatient day limit.	*Same as above*	*Same as above*	*Same as above*
Partial Hospitalization—Mental Illness[1][2][3] Up to 60 days per fiscal year (October 1–September 30). Minimum of three hours per day, five days per week of therapeutic services.	*Same as above*	*Same as above*	*Same as above*

1. Requires prior authorization.

2. TRICARE Standard beneficiaries may have to pay up to 15 percent over the maximum allowable charge when the provider does not accept assignment (balance billing). Treatment must be provided by TRICARE-authorized institutional providers.

3. Cost-share and daily inpatient charges are subject to change at the beginning of each fiscal year (October 1–September 30).

*4. **Note:** A nonavailability statement (NAS) is required for all nonemergency inpatient admissions with TRICARE Extra and TRICARE Standard. This does not apply to admissions to RTC, PHP, and SUDRF facilities.*

5. All services provided by Pastoral Counselors, Licensed Professional Counselors (LPCs), or Licensed Mental Health Counselors (LMHC) must be referred and supervised by a physician (M.D. or D.O.).

Non-covered Behavioral Health Services

The following behavioral health services are not covered under TRICARE:

- Environmental ecological treatments
- Megavitamin or orthomolecular therapy
- Transcendental meditation
- Rolfing
- Z therapy
- Primal therapy
- Bioenergetic therapy
- Carbon dioxide therapy
- Guided imagery
- Sedative action electrostimulation therapy
- Aversion therapy (including electric shock and the use of chemicals for alcoholism, except for Disulfiram, which is covered for the treatment of alcoholism)
- Narcotherapy with LSD
- Marathon therapy
- Hemodialysis for schizophrenia
- Training analysis
- Filial therapy
- Sexual dysfunction therapy
- Eye movement desensitization and reprocessing training
- Psychosurgery (Surgery for the relief of movement disorders, electroshock treatments, and surgery to interrupt the transmission of pain along sensory pathways are not considered psychosurgery)
- Behavioral health services and supplies related solely to obesity and/or weight reduction
- Biofeedback for psychosomatic conditions
- Counseling services such as nutritional counseling, stress management, marriage counseling, or lifestyle modifications
- Custodial nursing care
- V-Codes
- Experimental procedures
- Educational programs
- Smoking cessation programs
- Therapy for developmental disorders such as dyslexia, developmental mathematics disorders, developmental language disorders, and developmental articulation disorders

Sexual Disorders

Sexual dysfunction is characterized by disturbances in sexual desire and by the psychophysiological changes that characterize the sexual response cycle cause marked distress and interpersonal difficulties. Any therapy, service, or supply provided in connection with sexual dysfunction or inadequacies is excluded from TRICARE coverage. Exclusions include therapy, services, or supplies for these disorders/dysfunctions:

- Sexual desire disorders (e.g., hypoactive sexual desire disorder, sexual aversion disorder)
- Sexual arousal disorders (e.g., female sexual arousal disorder, male erectile disorder)
- Orgasmic disorders (e.g., female orgasmic disorder, male orgasmic disorder, premature ejaculation)
- Sexual pain disorders (e.g., dyspareunia, vaginismus)
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction
- Sexual dysfunctions not otherwise specified, including those with organic or psychogenic origins
- Paraphilias (e.g., exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and paraphilia not otherwise specified)
- Gender identity disorders—Characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one's assigned gender

Billing and Claims Processing

Claims for the TRICARE South Region are processed by PGBA, LLC (PGBA). They can be reached, toll-free at 1-800-403-3950.

Electronic Claims

TRICARE will require your claims to be filed electronically. There are many benefits from filing TRICARE claims electronically, which include:

- Improved cash flow to the provider—On average, TRICARE electronic claims process about 2-3 weeks faster than paper claims. This, combined with the elimination of mail time, means you will receive your TRICARE payments much faster if you file your claims electronically.
- Reduced postage and paper handling costs
- Elimination of data entry errors
- Better audit trail—Electronic media claims (EMC) response reports are available to show you which claims were accepted for processing. Also, front-end EMC edits give you much faster feedback regarding problems with your claims, allowing you to correct and resubmit them quickly instead of taking weeks.
- Real-time claims processing if you are using XPressClaim on www.mytricare.com
- Electronic remittance advice (ERA) and electronic funds transfer (EFT)—Network providers who file all of their TRICARE claims electronically are eligible to receive ERAs and EFTs.

Humana Military Healthcare Services, Inc. offers innovative solutions to allow you to file your claims electronically. These make filing TRICARE EMC easier than it has ever been before.

XPressClaim on www.mytricare.com

Imagine filing your TRICARE claims while your patients are still in your office and getting the payment results right away. This can be accomplished using XPressClaim. It is secure, easy to use, fast, and free.

eZ TRICARE Claims

Want to avoid re-keying your claims? Then consider using eZ TRICARE Claims. With eZ TRICARE Claims, you can upload batches of claims directly from your practice management system. There is no software to install and no additional data entry for your TRICARE claims. eZ TRICARE Claims can accept a variety of claims formats, including National Standard Format (NSF) and ASC X12 837. For more information, call ValueOptions.

Clearinghouses

TRICARE claims are received from a large number of EMC clearinghouses. To see a current list, visit www.humana-military.com. Contact your current vendor to find out what needs to be done to send claims to TRICARE.

HIPAA Transaction Standards and Code Sets

The Health Insurance Portability and Accountability Act (HIPAA) final rule on Transaction Standards and Code Sets mandates that all health care providers, plans, and clearinghouses use new standard formats when conducting certain transactions electronically. For the new contract, the HIPAA standards will be in place, enabling health care providers to submit standard electronic transactions for eligibility, authorization, referrals, claims, or claims status. For your TRICARE claims, the following standard formats must be used:

- ASC X12N 837—Health Care Claim: Professional, Version 4010 and Addenda
- ASC X12N 837—Health Care Claim: Institutional, Version 4010 and Addenda

When fully implemented, TRICARE contractors and other health care payers will be prohibited from accepting or issuing transactions that do not meet the new standards. In order to avoid future cash flow disruptions, it is imperative that all providers convert to the HIPAA-compliant claims formats.

TRICARE Participating and Nonparticipating Providers

Network providers must accept assignment (participate) on every claim. Non-network providers may elect to accept assignment (participate) on claims filed on behalf of the beneficiary. When non-network providers elect not to accept assignment on claims, they are considered nonparticipating providers. When providers do not accept assignment, claim reimbursements are directed to the beneficiary.

Important Claim Tips

- Network providers must file TRICARE patient claims, even when the patient has other health insurance (OHI).
- Hospital and other institutional claims must be filed on a UB-92 form.
- The CMS-1500 form is used for filing claims for professional services.
- TRICARE is secondary to private insurance policies or coverage provided through the beneficiary's place of employment.
- Amounts, which have been denied by the other coverage simply because the claim was not filed in a timely manner (with the other coverage) or because the beneficiary failed to meet some other requirements of coverage, cannot be paid.
- Pre-authorization is required for those services, previously listed, that will be billed to TRICARE, even when the beneficiary has OHI.
- Professional providers use CPT codes and facilities use revenue and HCPCS (if required) codes to bill for services.
- Behavioral health care includes the ICD-9 diagnosis range: 290.0–314.9
- Only physicians and other providers licensed or certified as behavioral health care clinicians may bill for psychiatric CPT codes or ICD-9 diagnoses.
- Only one initial evaluation (CPT Code 90801) should be billed unless a second evaluation is pre-authorized.
- Balance billing a beneficiary is not permitted.
- Providers should note that beneficiaries must agree in advance of any non-covered service procedure, in writing, to be responsible for any specified non-covered services. The patient is "held harmless" in cases of non-covered services provided by a network provider without specific, advance written agreement by the patient for each non-covered service. A general waiver does not meet this requirement.
- TRICARE provider claim filing limits require claims to be submitted to PGBA for payment within one year from the date of service rendered.
- To check claims status, go to www.humana-military.com or call PGBA at 1-800-403-3950. These services are available 24 hours a day, seven days a week.
- TRICARE supplemental insurance policies DO NOT qualify as OHI. When only a supplemental policy is involved, file the TRICARE claim first.
- Providers should contact PGBA directly with questions or for assistance regarding claims and can access the PGBA Web site at www.mytricare.com.

Behavioral Health Care Management

Utilization management is a process that manages the beneficiary at the point-of-care through prospective review, concurrent review, retrospective review, case management, discharge planning, and aftercare planning activities.

Prospective Review

Prospective review is conducted when a certain procedure/service requires a medical necessity review. The review is performed under the direction of a behavioral health clinician, and its purpose includes the following:

- Determining medical necessity
- Evaluating proposed treatment
- Assessing level of care required
- Determining appropriate level of care prior to admission
- Identifying potential for discharge planning needs and determining whether the case meets care coordination or case management criteria
- Identifying potential quality-of-care issues

Physicians and/or peer reviewers perform second-level reviews.

Concurrent Review

Concurrent review is a process of continual reassessment of the beneficiary's needs during treatment. Concurrent review activities monitor the patient for appropriate level of care and identify potential care coordination, discharge needs, and case management candidates. The behavioral health clinician responsible for concurrent review evaluates the beneficiary's level-of-care needs during hospitalization. Based on medical determinations of levels of assistance that may be required, an entire episode of medical care may be adapted to fit the beneficiary's status and needs. Components may include:

- A continuum of health care based on identified needs and goals
- Design and adaptation of health care initiatives for the beneficiary
- Identification of assistance needs throughout an entire episode of care
- Beneficiary and family education

Retrospective Review

When a facility determines that treatment falls within the behavioral health ICD-9 code range of 290.0–314.9, they must contact ValueOptions at 1-800-700-8646 for a behavioral health authorization. Care rendered without authorization will be reviewed retrospectively, and may result in a penalty to the provider of up to 50 percent. The cost of this penalty will be borne by the provider, and the beneficiary will be held harmless. To obtain a retrospective review, mail a copy of the medical record, along with a request for retrospective review to:

ValueOptions
Retrospective Review
P.O. Box 551188
Jacksonville, FL 32255-1188
Or fax to: 1-904-996-2059

Case Management

Certain beneficiaries may require more intensive management and coordination of care. These high-risk beneficiaries may be eligible for case management through ValueOptions. Case management identifies links and provides intensive coordination of mental health and substance use services to high-risk beneficiaries to assist them in maintaining an optimal level of clinical stability.

Case managers link beneficiaries with TRICARE resources, MTFs, and state, federal, and local community resources, and they teach them how to advocate for their needs. By calling ValueOptions, you can make a referral for a case management evaluation. If a beneficiary is accepted for case management services, they will be assigned a case manager who will contact the beneficiary to assist in coordination of care and accessing necessary available resources.

Discharge Planning

Discharge planning is an important function that facilitates the transition of the beneficiary into a less-restrictive level of care. Behavioral health providers are expected to make discharge planning a routine part of treatment. Discharge planning services are automatically considered for all TRICARE beneficiaries in facilities in the South region where ValueOptions provides utilization management services. Coordination of discharge planning will occur during all initial and concurrent reviews. The objectives of discharge planning include:

- Minimize inappropriate use of hospital resources
- Evaluate acuity of the cases to project resources necessary to affect positive discharge planning
- Identify and use cost effective care sites when clinically appropriate
- Prevent unnecessary admissions/avoid readmissions caused by incomplete course of treatment
- Locate and use all alternative sources of available funding
- Avoid either under or over utilization of health care services

Discharge planning is thorough and unique to each case. The patient is to be provided with specific discharge plans and aftercare treatment, including detailed placement plans and professional follow-up. Aftercare appointments should occur as early as possible but not later than 30 days after the discharge. ValueOptions will authorize all medically necessary aftercare services to ensure continuity of care.

Appeals and Reconsiderations

If behavioral health services have been denied, providers may request a reconsideration by submitting a written request, a copy of the denial letter, and documentation that supports the clinical rationale for their treatment decisions. A copy of the necessary components of the medical record must be submitted with the written request to:

ValueOptions Behavioral Health
Attn: Appeals and Reconsideration Department
P.O. Box 551138
Jacksonville, FL 32255-1138

Providers will be notified, in writing, of the reconsideration decision within 30 days from the date of the reconsideration request. If the initial denial determination is upheld, the provider will be notified, in writing, of the right to request a second reconsideration.

Proper appealing parties for medical necessity include:

- A TRICARE beneficiary (including minors)
- A TRICARE-certified provider of services
- Any party appointed by the beneficiary

If the proper appealing party cannot or does not wish to pursue the appeal personally, or wishes to have another person directly assist in pursuing an appeal, the appealing party can appoint a representative to act in his or her behalf at any level of the appeal process. The appointment of a representative must be in writing and must be signed by the proper appealing party, or an individual can be appointed to act as a representative by a court of competent jurisdiction. Appeals must be submitted, in writing, to ValueOptions.

Incident Reporting Requirements

Any serious occurrence involving a TRICARE beneficiary while receiving services at a TRICARE-certified treatment program (Residential Treatment Center (RTC), partial hospitalization program (PHP) facility, or freestanding SUDRF) must be reported to the National Quality Monitoring Contractor (NQMC). Reportable occurrences are defined by TRICARE as follows: a life-threatening accident, a patient death, a patient elopement, a suicide attempt, cruel or abusive treatment, physical or sexual abuse, or any equally dangerous situation. TRICARE participation agreements outline specific requirements.

The point of contact for TRICARE incident reporting is Maximus, Inc. Review of serious incidents is included as a facility certification function. The address for Maximus is:

NQMC–Maximus
1600 E. Northern Ave.
Suite 100
Phoenix, AZ 85020

Behavioral Health Medical Record Documentation

The following information should be included in each individual beneficiary record:

- Beneficiary identification (name and identification number) on each page
- Allergies
- Date and time of visit
- Chief complaint or problem
- History of problem
- Physical assessment
- Diagnosis/impression
- Appropriate discharge planning
- Treatment plan goals
- Legible provider name(s) and signature(s)

Note: The credentials or provider type for each provider represented in the record should appear each time.

Inpatient Medical Record Documentation for Behavioral Health Services

All inpatient (including Residential Treatment Center (RTC) and partial hospitalization program (PHP)) behavioral health records must contain the following:

- Psychiatric admission evaluation report within 24 hours of admission
- History and physical exam within 24 hours of admission (**Note:** The complete report must be documented within 72 hours of acute and RTC programs and within three working days for PHPs.)
- Individual and family therapy notes within 24 hours of procedure for acute care, detoxification, and RTC programs, and within 48 hours for PHPs
- Preliminary treatment plan within 24 hours of admission
- Master treatment plan within five calendar days of admission for acute care, 10 days for RTC care, five days for full-day PHPs, and seven days for half-day PHPs
- Family assessment report within 72 hours of admission for acute care and within seven days for RTCs and PHPs
- Nursing assessment report within 24 hours of admission
- Nursing notes at the end of each shift for acute and detoxification programs, after every 10 visits for PHPs, and at least once a week for RTCs
- Physician notes daily for intensive treatment, detoxification and rapid stabilization programs, twice per week for acute programs, and once per week for RTCs and PHPs
- Group therapy notes once per week
- Ancillary service notes once per week

Additionally, any consultations, studies, and treatments must be documented with indication of results. A statement of informed consent must also be provided for any invasive treatments.

Individual Provider (Office) Medical Record Documentation for Behavioral Health Services

Individual providers should keep a separate record on each beneficiary. All documentation in the beneficiary record should be signed by the treating provider and list the provider's licensure. Records should contain three broad categories of information:

1. Administrative information related to the patient

- Patient identification
- Informed consent for evaluation, treatment and communications signed by the beneficiary or legal guardian
- Signed Patient Bill of Rights
- Documentation showing communication with the beneficiary's primary care physician

2. An individualized treatment plan

- Identified problems as determined by the beneficiary and/or family and the therapist
- Specific treatment interventions and goals
- Discharge plans

3. Documentation of assessments obtained through examination, testing, and observation

- Date, time, and length of therapy session
- Patient's current clinical status evidenced by the presenting signs and symptoms
- Content of therapy session
- Therapeutic intervention(s) used and a description of the beneficiary's response
- Summary of the beneficiary's progress toward the treatment goals and discharge

Medication Management Records for Behavioral Health Services

To adhere to TRICARE procedures and requirements, medication management records should include:

- A completed medication flow sheet or progress notes documenting current psychotropic medication(s), dosage(s), and date(s) of dosage changes
- Documentation of beneficiary education regarding possible medication side effects
- Documentation that the reason for medication was explained to the beneficiary
- Documentation of education for women of child-bearing age to avoid becoming pregnant while taking psychotropic medication and to notify psychiatrist immediately upon becoming pregnant
- Documentation of beneficiary understanding of medication education
- Record reflecting that Drug Enforcement Agency-scheduled drugs are avoided in the treatment of beneficiaries with a history of substance abuse/dependency.

Outside Resources Documentation for Behavioral Health Services

If outside resources are utilized for care, the following documentation must be included:

- Documentation of the utilization of resources outside therapeutic encounters, including appropriate preventive services such as relapse prevention strategies, lifestyle changes, stress management, wellness programs, and referrals to community resources
- Prompt referral of beneficiaries who become homicidal, suicidal, or unable to conduct activities of daily living to the appropriate level of care

Notes

Notes

Roles, responsibilities, and procedural information for operating as a TRICARE provider

Health Care Management and Administration

Referrals and Authorizations

Referrals

When a TRICARE Prime beneficiary's primary care manager (PCM) is unable to provide a specialized medical service, the PCM must contact Humana Military to request a referral. Humana Military issues a referral when a TRICARE Prime beneficiary needs specialized medical services from a **civilian professional or ancillary provider only if services are not available at the military treatment facility (MTF) or at the PCM's office**. The MTF is always the primary source of care for TRICARE beneficiaries. The MTF has the right of first refusal to provide care for a TRICARE beneficiary.

Referral requests may be submitted via the "Provider Resources/Online Provider Services" feature at www.humana-military.com, or by calling health care finders (HCFs) through Humana Military's TRICARE Service Line at 1-800-444-5445. HCFs can assist with all referrals during normal business hours.

Tips for Making Referrals

- All referrals must be made to network providers. Network providers are listed in the "Provider Resources/Online Services/Find a Provider" feature at www.humana-military.com.
- Submit a referral on the Web site, via fax, or over the phone:
    - The quickest way to submit referral information is online via the "Provider Resources/Online Provider Services/Referrals and Authorizations" feature at www.humana-military.com. Web site referral services have been automated, and in many cases provide immediate response and confirmation.
    - The next quickest way is to fax the Patient Referral Authorization Form (PRAF). The Humana Military PRAF fax number is 1-877-548-1547, and a sample of this form is available in the section titled "Provider Tools" or your Provider Welcome Kit.
    - If you are having trouble with the Web or fax, call an HCF at Humana Military's TRICARE Service Line: 1-800-444-5445. However, you may incur wait time.
- For behavioral health referrals, contact ValueOptions at 1-800-700-8646.
- When completing the referral, always have the beneficiary sponsor's Social Security number, diagnosis, and clinical data explaining the reason for the referral.
- Check referrals via the Humana Military Web site at www.humana-military.com. To check the referral status by phone, call Humana Military's TRICARE Service Line at 1-800-444-5445 and select the option "To check the status of an authorization or previously requested service."
- The HCF will send the referral by AutoFax to the PCM and the referred provider when the care is authorized. Authorization is based on whether or not the referral is for a covered service.
- For urgent referrals, call the HCF or fax the PRAF to the HCF.
- The referral will clearly specify the services authorized, the number of visits, and the timeframe in which the visits must be completed.
- If services are needed beyond the scope of the referral, additional services must be approved through the PCM.
- Humana Military will notify the beneficiaries of an approved referral.

Referral Verification by AutoFax

AutoFax is a fax-driven system that allows automatic transmission of referrals to PCMs and specialists. AutoFax streamlines and coordinates the referral process by synchronizing the referral information received by the requesting provider. The system will automatically generate a faxed copy of the approved referral to the PCM and the referred-to provider. The referral will include the following information:

- Patient demographic information
- Information about the referral
- Authorized services
- Referring PCM
- Humana Military phone and fax numbers

To ensure timely receipt of AutoFax transmissions, it will be necessary to leave fax machines on after hours, including weekends. Please report any fax number changes to your provider relations representative. Please program your office/referral fax number into your fax machine to ensure that it appears on your referral request.

Prior Authorizations

An authorization is issued for requested services, procedures, or admissions that require medical necessity review prior to services being rendered (see chart on the following page). Prior authorizations are based on medical necessity and are NOT a guarantee of payment. Provider penalties may be applied when a TRICARE provider fails to obtain prior authorization or exceeds the scope of an approved referral/authorization.

Prior authorizations may be requested by one of three ways:

1. Submit requests online via the Humana Military Web site at www.humana-military.com.
2. Fax a completed PRAF form to 1-877-548-1547, and a sample of this form is available in the section titled "Provider Tools" or your Provider Welcome Kit.
3. Call an HCF at Humana Military's TRICARE Service Line: 1-800-444-5445.

Tips for Submitting Authorizations

For inpatient or outpatient prior authorizations, avoid waiting on the phone by submitting the request online at www.humana-military.com. You may also fax the request, including clinical information, or call an HCF at Humana Military's TRICARE Service Line: 1-800-444-5445. Make sure you have the following information:

- Sponsor ID, Social Security number, address
- Patient name, date of birth, relationship to sponsor
- Admitting hospital, date, time, physician tax ID, name and mailing address
- Clinical conditions for surgery, including CPT codes

You may check the status of your prior authorization request online at the Humana Military Web site at www.humana-military.com, or by calling the Humana Military TRICARE Service Line at 1-800-444-5445. Most requests for authorization can be completed while you are on the phone or within 24 hours of receipt of all required information. Authorizations are valid only for care that begins within 30 days of receiving authorization. Providers may evaluate, stabilize, and treat patients for whom a full admission is not clear by using the 23-hour observation status. If after 23 hours the patient must continue as an inpatient, Humana Military must be notified.

Procedures Requiring Prior Authorization in the South Region

Description of Service or Procedure	CPT-4 CODE
Adjunctive dental	See TRICARE Policy Manual, Chapter 8, Section 13.1
Home health services	See TRICARE Reimbursement Manual, Chapter 12, Section 4
Hospice care	See TRICARE Reimbursement Manual, Chapter 11, Section 3
Program for Persons with Disabilities	See TRICARE Policy Manual, Chapter 12, Section 9
Transplant for solid organ and stem cells	See TRICARE Policy Manual for specific transplant
Hysterectomy (TAH and laparoscopy surgical, with vaginal hysterectomy)	58150-58240, 59525, 58260-58285, 58550, 58290-58294 58552-58554
Termination of pregnancy	59812-59857, 59100
Reduction mammoplasty	19318
Septoplasty	30520
Uvulopalatopharyngoplasty (UPPP)	42145
Blepharoplasty	67904
Speech therapy	92507-92508
Durable Medical Equipment (DME)	
Electric hospital bed	E0260, E0265
Continuous Positive Airway Pressure (CPAP) Machine	E0601
Apnea monitor	E0618, E0619
Patient lifts	E0630, E0635
Pneumatic compressor	E0651
Bone stimulator	E0747-E0748
Continuous Passive Motion (CPM) Machine	E0935
Power vehicle or wheelchair	E1230, K0010
Orthotics	L0565, L1200, L1832, L1845, L1846, L1885, L1970, L2036, L3730
Prosthetics	L5645, L5700, L5980
Any miscellaneous code if line item rental or purchase price is greater than $500	E1399 and all other miscellaneous codes
Inpatient Hospital Stays	
Admissions or transfers to SNF, rehabilitation facilities, or long term acute care facilities.	N/A
Notification of admission within 24 hours of admission to acute care facility	N/A
Discharge notification	N/A
Concurrent reviews upon request by Humana Military	N/A
Behavioral Health Care Services	
Inpatient behavioral health admissions	See TRICARE Policy Manual, Chapter 7, Section 3.3-3.6
Psychoanalysis	90845
Psychological testing	96100, 96105, 96110, 96111
Neuropsychological testing	96115, 96117
Electroconvulsive therapy (ECT)	90870, 90871
Outpatient crisis intervention	90808, 90809, 90814, 90815

**These codes are subject to change.*

Out-of-Region Care

Emergency and Urgent Care

Cases of true emergencies are covered for TRICARE beneficiaries traveling away from home, whether they are in or out of their TRICARE region. The HCF should be notified within 24 hours of an emergency hospital admission. Nonemergency urgent care for TRICARE Prime enrollees must be approved by their PCM and authorized by an HCF. Without authorization, benefits are paid at the TRICARE Prime point-of-service (POS) level. Urgent care guidelines do not apply to behavioral health care services.

Routine Care

Routine care for TRICARE Prime enrollees traveling or living outside of the PCM's area is covered under the TRICARE Prime POS option.

Medical Record Documentation

Humana Military may review providers' clinical records on a random-sample basis to evaluate patterns of care and compliance with performance standards. Policies and procedures should be in place to help ensure that a beneficiary's medical record chart is appropriately organized and that confidentiality of the beneficiary's information is maintained. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

The following guidelines will assist you in documenting medical and surgical care in every individual patient record:

- The record must be legible to someone other than the writer.
- Every page in the record must contain the beneficiary's name or identification (ID) number.
- Personal/biographical data should include address, employer, home and work telephone numbers, and marital status.
- All entries in the medical record should contain author ID, which may be a handwritten signature, unique electronic identifier, or initials.
- All entries must be dated.
- Significant illnesses and medical conditions must be indicated on a problem list.
- Medication allergies and adverse reactions, if any, should be prominently noted in the record.
- Past medical history (for beneficiaries seen three or more times) should be easily identifiable and include serious accidents, operations, and illnesses.
- For children and adolescents (18 years and younger), past medical history should relate to prenatal care, birth, operations, and childhood illnesses.
- For beneficiaries 14 years and older who have been seen three or more times, information concerning use/abuse of cigarettes, alcohol, and controlled substances should be noted.
- A history and physical should be done no more than seven days before, or 48 hours after, admission by a doctor of medicine or osteopathy, or by an oromaxillofacial surgeon who has been granted such privileges by the medical staff, in accordance with state law. If a history and physical examination has been performed within 30 days, but greater than seven days, before admission, any changes must be described in the physician's admission note.
- Laboratory and other studies should be ordered, as appropriate, and documented properly.
- Working diagnoses should be consistent with findings.
- Treatment plans should be consistent with diagnoses.
- Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls, or visits, and the specific time of return should be noted in weeks, months, or "as needed."
- Unresolved problems from previous office visits should be addressed in subsequent visits.
- Reviews should be conducted for underutilization or overutilization of consultants.
- Consultant notes/results for a requested consultation must be entered on the chart.

- To signify review, all consultation, laboratory, and imaging reports filed in the chart should be initialed by the ordering practitioner. Review and signature by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, review by the ordering practitioner should be documented.
- Consultation, abnormal laboratory, and imaging study results should include an explicit notation of follow-up plans in the record.
- Individual records should be used to demonstrate whether the care was needed and if it was of such quality to meet the beneficiary's needs.
- Immunization records for children must be up-to-date, and an appropriate history must be made in the medical records for adults.
- Evidence that preventive screening and services were offered and accepted or rejected in accordance with the office's practice guidelines should be included in the record.
- In cases of unusual deaths, or in deaths of medical-legal and education interest, there should be documentation of request (consent or refusal) for an autopsy.
- Medical record documentation of injection(s) should include:
    - Name of drug
    - Time of administration
    - Dosage
    - Route of administration
    - Site of injection
    - Signature or initials of individual administering the medication.

Note: For immunizations, the lot number, manufacturer, verification that the Vaccine Information Statement was given to the patient or parent/guardian, and the name and address of the health care provider administering the vaccine must also be documented.

Utilization Management

Utilization management is a process that manages the beneficiary at the point-of-care through prospective review, concurrent review, case management, discharge planning and aftercare planning activities, and retrospective review.

Prospective Review

Prospective review is conducted when a certain procedure/service requires a medical necessity review. The review is performed under the direction of a registered nurse, and its purpose includes the following:

- Determining medical necessity
- Evaluating proposed treatment
- Assessing level of care required
- Determining appropriate level of care prior to admission
- Identifying potential for discharge planning needs and determining whether the case meets care coordination or case management criteria
- Identifying potential quality-of-care issues

Physicians and/or peer reviewers perform second-level reviews.

Concurrent Review

Concurrent review is a process of continual reassessment of the beneficiary's needs during an inpatient stay. Concurrent review activities monitor the patient for appropriate level of care and identify potential care coordination, disease-management/demand-management, discharge needs, and case-management candidates.

The care coordinator responsible for concurrent review evaluates the beneficiary's level-of-care needs during hospitalization. Based on medical determinations of levels of assistance that may be required, an entire episode of medical care may be adapted to fit the beneficiary's status and needs. Components may include:

- A continuum of health care based on identified needs and goals
- Design and adaptation of health care initiatives for the beneficiary
- Identification of assistance needs throughout an entire episode of care
- Beneficiary and family education

Case Management

Case management services are provided by Humana Military nurses or TRICARE beneficiaries with complex health needs and should be referred to Humana Military case management for an evaluation. The following conditions call for mandatory referral to case management.

- HIV positive patients: T-cell count below 400
- Premature infants: Ventilator-dependent more than 24 hours and weighing less than 1500 grams
- Transplants, including peripheral stem cell
- Acute inpatient rehabilitation (not skilled nursing facility with physical therapy only)
- New quadriplegics and paraplegics
- New head injury with residual deficits after three days which interferes with employment or activities of daily living
- All ventilator-dependent patients
- OB patients with identified risk factors
- Potential hospice patients
- Burn patients requiring a referral to a burn unit
- Patients admitted to an acute hospital three or more times within 90 days with the same diagnosis
- Complicated cardiovascular patients
- Cystic fibrosis patients
- Sickle cell anemia patients

This list is not all inclusive and is subject to change. Any beneficiary with a complex case who may benefit from case management is eligible for an evaluation.

Discharge Planning

The patient care coordinator performs concurrent review and discharge planning. Discharge planning and case management services are automatically considered for all TRICARE beneficiaries in facilities in the South Region where Humana Military provides utilization management services. The objectives of discharge planning include:

- Minimize inappropriate use of hospital resources.
- Evaluate acuity of the cases to project resources necessary to affect positive discharge planning.
- Identify and use cost effective care sites when clinically appropriate.
- Prevent unnecessary admissions/avoid readmissions caused by incomplete course of treatment.
- Locate and use all alternative sources of available funding.
- Avoid either under or over utilization of health care services underutilization or overutilization.

Retrospective Review

Retrospective review is conducted when a certain procedure/service requires a medical necessity review and authorization was not obtained prospectively. The review is performed under the direction of a registered nurse, and aspects of the retrospective review include the following:

- Inpatient medical necessity and appropriateness of level of care
- Medical necessity of surgical and other procedures that affect diagnosis-related group (DRG) assignment
- Potential quality problems associated with premature discharge identified by first level review using InterQual or mental health criteria and confirmed by physician review
- Mental health claims review, if present in the sample
- Discrepancies between the medical record and the claim in regard to diagnoses, procedures, and discharge status
- Discrepancies between the prospective review information and the medical record

National Quality Monitoring Contractor

Maximus, Inc., of Reston, Virginia, is the TRICARE National Quality Monitoring Contractor (NQMC) and will assist Department of Defense (DoD) Health Affairs, TRICARE Management Activity (TMA), MTF market managers, and the new TRICARE Regional Offices (TROs) by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the Military Health System. The NQMC will review care

provided by Humana Military network providers and subcontractors on a limited basis. The NQMC is part of TRICARE's Quality and Utilization Peer Review Organization Program, in accordance with 32 CRF 199.15.

Clinical Quality Management

The Humana Military Quality Management Department is responsible for oversight of clinical care provided to TRICARE beneficiaries. TRICARE providers must agree to participate in clinical quality studies and to make their medical records available for review for quality purposes. TRICARE Prime beneficiaries and PCMs receive reminder letters from the Humana Military Quality Management Department to promote awareness of recommended prevention care services.

Fraud and Abuse

Program integrity is a comprehensive approach to detecting and preventing fraud and abuse. Prevention and detection are a result of functions of the pre-payment control system, the post-payment evaluation system, quality assurance activities, reports from beneficiaries, and identification by a provider's employees or Humana Military staff.

The TRICARE Management Activity (TMA) has a specific office to oversee the fraud and abuse program for TRICARE. The Program Integrity Branch analyzes and reviews cases of potential fraud (intent to deceive or misrepresent to secure unlawful gain). Some examples of fraud are as follows:

- Billing for services, supplies, or equipment not furnished or used by the beneficiary
- Billing for costs of non-covered or nonchargeable services, supplies, or equipment disguised as covered items
- Violation of the participation agreement that results in the beneficiary being billed for amounts that exceed the TRICARE allowable charge or cost
- Duplicate billings—e.g., billing more than once for the same service, billing TRICARE and the beneficiary for the same services, submitting claims to both TRICARE and other third parties without making full disclosure of relevant facts or immediate full refunds (in the case of overpayment by TRICARE)
- Misrepresentations of dates, frequency, duration, or description of services rendered or the identity of the recipient of the service or who provided the service
- Reciprocal billing, i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed
- Practicing with an expired or revoked license, since an expired or revoked license in any state or territory of the U.S. will result in a loss of authorized provider status under TRICARE
- Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE. The Program Integrity Branch also reviews cases of potential abuse (practices inconsistent with sound fiscal, business, or medical procedures and services not considered to be reasonable and necessary). Such cases often result in inappropriate claims for TRICARE payment.

Some examples of abuse are as follows:

- A pattern of waiver of beneficiary (patient) cost-share or deductible
- Charging TRICARE beneficiaries rates for services and supplies that are in excess of those charged the general public, e.g., commercial insurance carriers or other federal health benefit entitlement programs
- A pattern of claims for services that are not medically necessary, or if necessary, not to the extent rendered
- Care of inferior quality (does not meet accepted standards of care)
- Failure to maintain adequate clinical or financial records
- Unauthorized use of the term "TRICARE" in private business
- Refusal to furnish or allow access to records

Providers are cautioned that unbundling, fragmenting, or code gaming to manipulate the Physicians' CPT codes as a means of increasing

reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such a practice can be considered fraudulent and abusive.

Fraudulent actions can result in criminal or civil penalties. Fraudulent or abusive activities may result in administrative sanctions, including suspension or termination as an authorized provider. The TMA Office of General Counsel works in conjunction with the Program Integrity Branch in dealing with fraud and abuse. The DoD Inspector General and other agencies investigate TRICARE fraud.

To report suspected fraud and/or abuse, call the Humana Military Fraud and Abuse Hotline at 1-800-333-1620.

Grievances

If a provider or beneficiary has a concern about the level or quality of services (or care) received through the TRICARE program, he or she has a right to file a grievance with Humana Military.

A grievance is a written complaint on a non-appealable issue that deals primarily with a perceived failure of a network provider or an employee of Humana Military or its subcontractor(s) to furnish the level or quality of service or care expected by a beneficiary or provider. The following are examples of issues subject to the grievance process:

- Complaints concerning the quality of a clinical or non-clinical service received by a beneficiary
- Complaints regarding wait times in a provider's office, physician or employee behavior, adequacy of facilities, and other similar concerns
- Complaints about the level of customer service provided by a provider, contractor, or subcontractor staff

Grievances do not pertain to claims payment issues or denials of medical treatment authorizations. These are considered to be appeals and are described in the next section.

Grievances are directed first to the TRICARE Service Center (TSC) for resolution. If a complaint is not resolved by the TSC, a written grievance may be filed with the market office. The grievance will be investigated and adjudicated by the appropriate market office within 60 days of its receipt. The parties involved in the grievance will then be informed of the determination. If the parties are still not satisfied, they can request a second level review.

Appeals

TRICARE beneficiaries have the right to appeal decisions made by TRICARE Management Activity (TMA) or Humana Military for another opinion on the decision. The appeals process varies, depending on whether the denial of benefits involves medical necessity determination, factual determination, provider authorization, or a provider sanction. All initial and appeal denials explain how, where, and by when to file the next level of appeal. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation.

Proper Appealing Parties

- The TRICARE beneficiary (including minors)
- The non-network participating (accepts assignment) provider of services
- A non-network and participating (accepts assignment) provider appealing a pre-admission/pre-procedure denial (when services have not been rendered)
- A provider that has been denied approval as an authorized TRICARE provider or who has been terminated, excluded, suspended, or otherwise sanctioned
- A person who has been appointed in writing by the beneficiary to represent him/her in the appeal
- An attorney filing on behalf of a beneficiary
- A custodial parent or guardian of a beneficiary under 18 years of age

A network provider is never an appropriate appealing party unless the beneficiary has appointed the provider, in writing, to represent him or her for the purpose of the appeal. To

avoid possible conflict of interest, an officer or employee of the United States—such as an employee or member of a uniformed service, including an employee or staff member of a Uniformed services legal office, or a beneficiary counseling and assistance coordinator, subject to exceptions in Title 18, United States Code, Section 205—is not eligible to serve as a representative. An exception usually is made for an employee or member of a uniformed service who represents an immediate family member.

Medical Necessity Determinations

Medical necessity determinations are based solely on medical necessity—whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition. Generally, determinations relating to mental health benefits are considered medical necessity determinations. There are expedited procedures for appealing decisions denying requests for pre-authorization of services and requests for continued inpatient stays. If an expedited appeal is available, the initial and appeal denial decisions will fully explain how to file an expedited appeal.

Factual Determinations

Factual determinations involve issues other than medical necessity. Some examples of factual determinations include: coverage issues (i.e., determining whether the service is covered under TRICARE policy or regulation), all foreign claims determinations, and denial of a provider's request for approval as a TRICARE-authorized provider.

Provider Sanction Determinations

Providers who request approval as TRICARE-authorized providers but are denied approval by either TMA or Humana Military may appeal those decisions and request a reconsideration. Provider sanction determinations occur when providers are expelled from TRICARE. Providers may be sanctioned by TRICARE because of failure to maintain credentials, provider fraud, abuse, conflict of interest, or other reasons. Only the provider or his or her representative can appeal. If the sanctions are appealed, an independent hearing officer will conduct a hearing administered by the TMA Appeals and Hearings Division.

Providers who are not eligible for authorization by TRICARE because of fraud and abuse against another Federal or federally funded program or a state or local licensing authority, e.g., Medicare or Medicaid, may not appeal through the TRICARE system. Determination is the responsibility of the uniformed services.

Non-appealable Issues

- Point-of-service determinations, with the exception of whether services were related to an emergency and therefore exempt from the requirement for referral and authorization
- Allowable charges (the TRICARE-allowable cost or charge for services or supplies is established by regulation)
- A beneficiary's eligibility, since this determination is the responsibility of the uniformed services
- Provider sanction (the provider is limited to exhausting administrative appeal rights)
- Network provider/contractor disputes
- Denial of services from an unauthorized provider
- Denial of a treatment plan when an alternative treatment plan is selected
- Denial of services by a primary care manager (PCM)

Waiver of Liability

Subject to application of other TRICARE definitions and criteria, the principle of waiver of liability is summarized as follows: If the beneficiary did not know, or could not reasonably be expected to know, that certain services were potentially excludable from the TRICARE Basic Program by reason of being not medically necessary, not provided at an appropriate level, custodial care, or other reason relative to reasonableness, necessity, or appropriateness (hereafter, all such services will be referred to as not medically necessary), then the beneficiary will not be held liable for such services and, under certain circumstances, payment may be made for the excludable services as if the exclusion for such services did

not apply. The TRICARE beneficiary can be held financially responsible in the following instances:

- If both the **non-network**, participating provider and the beneficiary knew the services were excluded
- If the beneficiary did not notify the **non-network**, participating provider of having TRICARE or
- If the beneficiary knew the services were excluded but the non-network, participating provider did not

Waiver of liability also does **not** apply to services provided by a network provider. Network providers may **never** bill beneficiaries for services denied for medical necessity or appropriateness. This requirement **does not apply** to TRICARE network pharmacies.

Notes

Notes

Guidelines and procedural information for claims and billing

Claims Processing and Billing Information

PGBA, LLC

PGBA, LLC (PGBA) is the Humana Military Healthcare Services, Inc. (Humana Military) partner for claims processing in the TRICARE South Region. Visit PGBA's Web site at www.mytricare.com for more information about PGBA and claims processing requirements.

TRICARE network providers must file their patient's TRICARE claims, even when the patient has other health insurance. TRICARE requires your claims to be filed electronically. Payments made to network providers for medical services rendered will not exceed 100 percent of the TRICARE allowable charge.

PGBA Contact Information

Phone:	1-800-403-3950
Fax:	1-803-713-0354
Mail:	PGBA South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031
E-mail:	Details on PGBA Web site
Web site:	www.mytricare.com

Claims Processing Standards and Guidelines

TRICARE requires your claims to be filed electronically with the appropriate HIPAA-compliant standard electronic claims format. If a non-network provider must submit claims on paper, TRICARE requires them to be submitted on either a CMS-1500 (professional charges) or a UB-92 (institutional charges) claim form. You will find guidelines for processing claims in the South Region in the information that follows.

Filing Electronic Claims

There are many benefits from filing TRICARE claims electronically. These benefits include:

- Improved cash flow—On average, TRICARE electronic claims process two to three weeks faster than paper claims. This combined with the elimination of mail time means that you will receive your TRICARE payments much faster if you file your TRICARE claims electronically.
- Reduced postage and paper handling costs
- Eliminates data entry errors
- Better audit trail—Electronic media claims (EMC) response reports show you which claims were accepted for processing. Also, front-end EMC edits give you much quicker feedback regarding problems with your claims, allowing you to correct and resubmit quickly instead of taking weeks.
- Real-time claims processing—If you're using XpressClaim℠ on www.mytricare.com (more information below), you can submit your claims online and instantly find out how much TRICARE will pay.
- Electronic remittance advice (ERA) and electronic funds transfer (EFT)—Network providers who file all of their TRICARE claims electronically are eligible to receive ERAs and EFTs.

Humana Military offers several innovative solutions to allow you to file your claims electronically. We believe that we have made filing TRICARE EMC easier than it has ever been before.

Electronic Claim Filing Options

XPressClaim on www.mytricare.com

Imagine filing your TRICARE claims while your patients are still in your office and getting the payment results right away—that's XPressClaim. It's secure, easy to use, fast, and free. You can submit secure TRICARE CMS-1500 claims and receive instant results. You can also print a patient summary receipt on the spot, while your patient is still in the office. To sign up, visit

www.mytricare.com and look for XPressClaim under the Provider section. Coming in 2004, you will also be able to file institutional (UB-92) claims through XPressClaim.

eZ TRICARE Claims on www.humana-military.com

Don't want to rekey your claims? Then you should consider using eZ TRICARE Claims available at www.humana-military.com. With eZ TRICARE Claims, you can upload batches of claims directly from your practice management system. There's no software to install, no data entry, and no cost for your TRICARE claims. eZ TRICARE Claims can accept a variety of claims formats, including National Standard Format (NSF), ASC X12 837, and even a CMS-1500 print file. To sign up for eZ TRICARE Claims, visit www.humana-military.com and select Online Provider Services.

Clearinghouses

We receive TRICARE claims from a large number of EMC clearinghouses. To see a current list, visit www.humana-military.com. You should contact your clearinghouse in order to find out what you need to do to send your TRICARE claims to us. Depending on the clearinghouse, we may be listed in their payer listing as Humana Military Healthcare Services (Payer ID = 61125) or as PGBA, our claims processing partner.

Electronic Data Interface (EDI) Gateway

If your system can create HIPAA-compliant claims formats and you prefer to send your claims directly to the payer, then PGBA's EDI Gateway may be right for you. PGBA built the EDI Gateway to handle all of their inbound and outbound HIPAA-compliant EDI transactions. The communications protocols supported are Asynchronous Dial-up, File Transfer Protocol (FTP), and CONNECT: Direct/NDM. To enroll or learn more about the EDI Gateway, contact the EMC Help Desk at 1-800-325-5920, menu option 2.

Other Helpful Hints

EMC Help Desk

PGBA operates an EMC Help Desk to assist you with any issues related to TRICARE electronic claims submissions. The telephone number is 1-800-325-5920, menu option 2. When you call, be sure to identify yourself as a TRICARE provider.

Supporting Documentation

Did you know that TRICARE claims that require some type of hard copy supporting documentation can still be filed electronically? PGBA has a dedicated fax to receive supporting documentation for electronically submitted claims. There is a special fax cover sheet that you should use in order to ensure that the documentation is correctly matched up to your claim. To get a copy of the fax cover sheet along with the fax phone number, call the EMC Help Desk at 1-800-325-5920, menu option 2 or download a copy from www.humana-military.com.

Claims with Other Health Insurance (OHI)

When filing claims that have OHI and TRICARE is secondary, you can avoid having to send a hard copy explanation of benefits (EOB) from the primary payer if you can transmit the required information electronically. We need to know the amount the primary insurance paid. If the primary insurance is a PPO, HMO, Medicare, or other insurance where there is a limited liability for the patient, then you also need to send us the OHI allowed amount. The OHI allowed amount represents the amount paid by the primary insurer plus any out-of-pocket expenses owed by the patient. In cases where the primary insurance paid zero, we need to know the reason nothing was paid.

TRICARE Provider IDs

In order to ensure correct claims payment, it is important that your claims be filed with the correct TRICARE Provider ID. The TRICARE Provider ID consists of your Tax ID or Social Security number. A 3-digit suffix is assigned to each provider ID for EMC submission. If you have multiple office locations, each office

location will have a different suffix. The suffix may also be used to distinguish departments within an institution (i.e. psych unit vs. medical/surgical). If you do not know your TRICARE Provider IDs, contact your Humana Military Provider Relations Representative. Including the appropriate office location suffix will ensure your check is mailed to the correct address.

On professional claims (CMS-1500) submitted by a group practice, the Rendering Physician ID must be submitted on each line of the claim. Note that this is a different number than the TRICARE Provider ID previously discussed. It is typically the SSN of the physician who rendered the service.

EMC Response Reports

To ensure that your electronic TRICARE claims are accepted by PGBA's system for processing, it is imperative that you reconcile your EMC transmissions with the EMC response reports returned by PGBA for every transmission. These responses show you the claims that were rejected as well as the claims that were accepted for processing. Reviewing these responses will ensure that EMC transmissions are not lost, and that rejected claims are identified so you can correct and resubmit them electronically for processing. If your TRICARE claims are submitted through a clearinghouse or other vendor, the PGBA responses are returned to that entity. Note that many clearinghouses perform their own edits and create their own reports which show how many claims were received from the provider and forwarded on to the payer, but only the PGBA responses show you which claims were received and accepted by PGBA for processing. If you are not sure if you are receiving these PGBA EMC responses, contact your vendor or the PGBA EMC Help Desk at 1-800-325-5920, menu option 2.

Common EMC Rejects

For a listing of common EMC reject reasons and solutions, visit the EMC Handbook at www.humana-military.com.

HIPAA Transaction Standards and Code Sets

The Health Insurance Portability and Accountability Act (HIPAA) final rule on Transaction Standards and Code Sets mandates that all health care providers, plans, and clearinghouses must use new standard formats when conducting certain transactions electronically. HIPAA standards were put into place on October 16, 2003, enabling health care providers to submit standard electronic transactions for eligibility, authorization, referrals, claims, or claims status. For your TRICARE claims, the following standard formats must be used:

- ASC X12N 837—Health Care Claim: Professional, Version 4010 and Addenda
- ASC X12N 837—Health Care Claim: Institutional, Version 4010 and Addenda

When fully implemented, TRICARE contractors and other health care payers will be prohibited from accepting or issuing transactions that do not meet the new standards. In order to avoid future cash flow disruptions, it is imperative that you begin working with your software vendor, clearinghouse, and PGBA now to convert to the HIPAA-compliant claims formats.

PGBA is ready to receive your TRICARE claims in the HIPAA standard formats. In order to transition successfully to the new formats, you should do the following:

- If you submit your claims through a clearinghouse or other vendor, contact them and find out what steps are necessary in order for your TRICARE claims to be transmitted to PGBA in the HIPAA standard claims format.
- If you submit directly to PGBA, your system will have to be able to produce the HIPAA standard claims format. Contact your software vendor to determine what changes are needed in your system and plan to test your updated software and migrate to the new formats as soon as possible.

If you need any assistance with transitioning to the new HIPAA standard formats for TRICARE, you may call the PGBA EMC Help Desk. Don't wait until it's too late. Take action today to ensure that you will be able to continue to benefit from the many advantages of filing your TRICARE claims electronically.

Filing Paper Claims

When filing a paper claim, make sure that you complete the CMS-1500 or UB-92 accurately and fully. Submit the paper claims to:

TRICARE South Region
Claims Department
P.O. Box 7031
Camden, SC 29020-7031

The most appropriate [Physician's] Current Procedural Terminology (CPT) code must be used when billing TRICARE—do not unbundle charges into separate CPT codes when a single code is more appropriate. If the CPT code(s) you are billing do not match the services authorized, the claim will be denied. Institutional providers billing with certain revenue codes require submission of Level II Health Care Procedural Coding System (HCPCS) codes for description of services and supplies.

Checking the Status of Your Claims

You can check on the status of your claims by visiting www.humana-military.com and clicking on "Online Provider Services" under the "Provider Resources" section. You may also call the PGBA voice response system at 1-800-403-3950. The line is available 24 hours a day, seven days a week; however, calling before 10 a.m. or after 5 p.m. or on any day other than Monday will help you get answers faster. To check on the status of a claim in writing or to resubmit a claim, direct your correspondence to:

TRICARE South Region
Customer Service Dept.
P.O. Box 7032
Camden, SC 29020-7032

Tracer Claims

When resubmitting an unchanged claim, write "Tracer" across the top of the claim form.

Corrected Claims

When submitting a correction to those claims previously accepted by PGBA for processing, write "Corrected" across the top of the claim form and resubmit the form. If a claim was previously rejected by PGBA, the claim will need to be corrected and resubmitted as a new claim.

Timely Filing

All TRICARE provider claims must be submitted to PGBA for payment within one year of the date the service was rendered or according to the provider contract.

"An Important Message from TRICARE" Letter

Inpatient facilities are required to provide each TRICARE beneficiary with a copy of the document "An Important Message from TRICARE." This document details the beneficiary's rights and obligations upon admission to the hospital. The signed document must be kept in the beneficiary's file. A new document is needed for each admission.

Returning Incorrect Payments

If you receive a duplicate or overpayment for a claim for TRICARE beneficiaries, TRICARE requests that this payment be returned to TRICARE Finance. Duplicate payments for TRICARE For Life claims should be returned to Wisconsin Physicians Service (WPS)—TRICARE For Life. Please include a copy of the remittance advice and a cover letter explaining exactly why the money is being returned. If a remittance advice is not included, please provide information about the beneficiary and the claim to help ensure that the refund is credited to the correct claim.

Return duplicate payments or overpayments to:

PGBA
Attn: TRICARE Finance
TRICARE Refunds/AG900 PGBA
P.O. Box 100279
Columbia, SC 29202-3279

Return **TRICARE For Life** overpayments to:

Wisconsin Physicians Service
Attn: TDEFIC
P.O. Box 77028
Madison, WI 53707-7028

If the provider does not return the overpayment, then PGBA may, after written notice, offset the amount of double payment against future claim payments.

ClaimCheck®

The TRICARE South Region uses ClaimCheck to review claims on a prepayment basis for unbundling. ClaimCheck is an automated product that contains specific auditing logic designed to evaluate professional billing for CPT coding appropriateness and to eliminate overpayment on professional and outpatient hospital claims.

Humana Military updates ClaimCheck annually with new coding based on current industry standards.

ClaimCheck Edits

Providers should follow CPT coding guidelines to prevent claim denials due to ClaimCheck editing. Any edits made by ClaimCheck will be explained by a message code on the remittance advice. ClaimCheck includes the following edit categories:

- Procedure unbundling
- Incidental procedure
- Mutually exclusive procedure
- Assistant surgeon requirements
- Age conflicts
- Gender conflicts
- Alternate code replacements
- Cosmetic procedures
- Unlisted procedures
- Modifier auditing
- Duplicate and bilateral procedures
- Preoperative (preop) and postoperative (postop) auditing billed
- Billed date(s) of service

The complete set of code edits is proprietary and, as such, cannot be released to the general public.

ClaimCheck Appeals

ClaimCheck is an automated clinical auditing tool. However, participating providers may have edits reconsidered through medical review. Issues appropriate for medical review include:

- Requests for verification that the edit was correctly applied to the claim
- Requests for an explanation of ClaimCheck auditing logic
- Situations in which the provider submits additional documentation substantiating that unusual circumstances existed

Participating providers interested in a medical review should write to Humana Military and provide additional documentation, if necessary. Following medical review, Humana Military may override the ClaimCheck edit and allow additional amounts to be paid. These requests should be sent to:

TRICARE South Correspondence
P.O. Box 7032
Camden, SC 29020-7032

Providers are not permitted to bill TRICARE beneficiaries for amounts considered unbundled or incidental by ClaimCheck. The following claims are not subject to TRICARE ClaimCheck: anesthesia, pharmacy, physical therapy, and inpatient institutional claims.

ClaimReview

Humana Military utilizes ClaimReview, an automated module in ClaimCheck designed to check claims for consistency in the diagnosis codes and procedure codes specified. To avoid necessary claim line denials, please pay particular attention to assign a diagnosis code that represents the reason the procedure is performed, as well as any diagnosis that will impact the treatment. However, if a line on your claim is rejected, first review your medical documentation for any additional diagnosis and if found, submit it on a "corrected claim."

If after review, other diagnoses cannot be found, a reconsideration can be requested by sending supporting medical record information to the correspondence address above. If you have any questions regarding this editing function, you may contact PGBA at 1-800-403-3950.

Proper Treatment Room Billing

Revenue Code 76x

Knowing when to use revenue code 76x (treatment or observation room) to indicate use of a treatment room can be confusing and can lead to inappropriate billing.

Providers may indicate revenue code 76x for the actual use of a treatment room **in which a specific procedure has been performed or a treatment rendered**. Revenue code 76x may be appropriate for charges for minor procedures and in the following instances:

- An outpatient surgery procedure code (10040-69990)
- Interventional radiology services related to imaging, supervision, interpretation, and the related injection or introduction procedure
- Debridement (11040-11044) performed in an outpatient hospital department

Revenue code 76x should not be used when the claim is submitted with a type of bill 83x and ASC procedure codes. ASC facility services are reimbursed under the ASC revenue code reimbursement. It should also not be used when the HCPCS code is blank or is an evaluation and management code (e.g., 99201-99205, 99211-99215).

Revenue Code Series 51x

TRICARE allowable charge reimbursement for covered medical services includes overhead and administrative costs. Therefore, revenue code series 51x is not reimbursed separately because it has been determined to be an overhead charge.

Charges submitted with revenue code series 51x are rebundled and denied with the explanation "Non-covered service(s). Procedure covered in prior paid service." Due to the rebundling of charges, the allowable charge determination is based upon the single comprehensive code, which includes the entire procedure as well as administrative costs. The following revenue codes are affected by this change:

Code	Description
510	Clinic, general class
511	Clinic, chronic pain
512	Clinic, dental
513	Clinic, psychiatric
514	Clinic, OB/GYN
515	Clinic, pediatric
516	Reserved
517	Clinic, family practice
518	Reserved
519	Clinic, other

If providers unbundle, ClaimCheck will indicate on the remittance advice that unbundled services were included with the global charge and will not be reimbursed separately. Providers may not bill beneficiaries for the services disallowed by ClaimCheck. Additionally, they may not insist beneficiaries sign a waiver accepting liability for unbundled amounts. Providers who do so may be found to have committed fraud and may be subject to sanctions, including termination. The only exception is for TRICARE For Life (TFL) claims. The bundling edit for revenue code 510 does not apply to TFL claims.

Regional Claims Telephone Numbers

Providers who have a claim issue or question regarding a TRICARE patient who normally receives care in another TRICARE region can call the appropriate number listed below for assistance. Providers should submit claims to the region in which TRICARE Prime beneficiaries reside and/or are enrolled.

North Region
1-877-TRICARE (1-877-874-2273)

Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, North Carolina, Illinois, Indiana, Kentucky, Michigan, Missouri (St. Louis area), Ohio, Tennessee, (Ft. Campbell area), West Virginia, and Wisconsin

West Region
1-888-TRIWEST (1-888-874-9378)

Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (except the Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner including El Paso only), Utah, Washington, and Wyoming

South Region
1-800-403-3950

Alabama, Florida, Georgia, Mississippi, South Carolina, Tennessee (excluding the Ft. Campbell area), Louisiana, Arkansas, Texas (excluding the El Paso area), Oklahoma, and Louisiana

Claims for Dual-Eligible Beneficiaries

Wisconsin Physicians Service (WPS) is the claims processor for all claims for beneficiaries who are eligible for both Medicare and TRICARE, regardless of where the services are received. If you currently submit claims on your patient's behalf to Medicare, you will not need to submit a claim to WPS. WPS has signed agreements with each Medicare carrier allowing them to submit claims directly to WPS. This includes TRICARE beneficiaries under the age of 65 who did not previously have their claims submitted by Medicare. After the Medicare carrier completes processing of the claim, it will be submitted electronically to WPS TRICARE For Life. Beneficiaries will receive a remittance advice from WPS once processing has completed. If you do not participate in Medicare, or the services you perform are not Medicare benefits, you will need to submit claims directly to WPS.

The following chart contains important contact information for you or your patients regarding dual-eligible claims:

Claims Submission	WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890
Appeals	WPS TRICARE For Life Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490
Program Integrity	WPS TRICARE For Life Attn: Program Integrity P.O. Box 7516 Madison, WI 53707-7516
Third Party Liability	WPS TRICARE For Life Attn: Third Party Liability P.O. Box 7897 Madison, WI 53707-7897
Refunds	WPS TRICARE For Life Attn: Refunds P.O. Box 7928 Madison, WI 53707-7928
Customer Service	WPS TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889
Toll-free	1-866-773-0404
Toll-free TDD Telephone	1-866-773-0405
Online	www.tricare4u.com

Claims for Active Duty Service Members

Claims for all active duty personnel should be mailed to:

PGBA
Active Duty Claims
P.O. Box 7031
Camden, SC 29020-7031

Claims for NATO Beneficiaries

Eligible family members of active duty service members of the foreign North Atlantic Treaty Organization (NATO) nations who are stationed in, or passing through, the U.S. in connection with their official duties are eligible for outpatient services under TRICARE Extra or TRICARE Standard. A copy of the family member's ID card will have a foreign identification number and indicate on the reverse "Outpatient Services Only." The eligibility for NATO beneficiaries is now maintained in the Defense Enrollment Eligibility Reporting System. Claims submission procedures are the same as for all other active duty family members.

Claims for CHAMPVA

CHAMPVA is not a TRICARE program. PGBA will forward CHAMPVA claims to the CHAMPVA Center in Denver, Colorado, within 72 hours of identification as CHAMPVA claims. A letter will be sent to the claimant informing them of the transfer. The letter includes instructions to submit all claims and direct any correspondence for CHAMPVA beneficiaries to the CHAMPVA Center. If you have a general question (other than one regarding an application) or if you need to file a claim for reimbursement for health care and the claim is older than one year, please send your request to:

VA Health Administration Center
CHAMPVA
P.O. Box 65023
Denver, CO 80206-9023
1-800-733-8387
www.va.gov/hac

For submitting new (less than one year old) health care claims within the one year claim filing deadline, please use:

VA Health Administration Center
CHAMPVA
P.O. Box 65024
Denver, CO 80206-9024

TRICARE and Other Health Insurance

TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, and the Indian Health Service or other programs/plans as identified by the TRICARE Management Activity (TMA). TRICARE beneficiaries who have other heath insurance (OHI) are not required to obtain referrals or prior authorizations for covered services, except for adjunctive dental care, the PFPWD, and stem cell and organ transplants. These services continue to require prior authorization even when OHI coverage exists. Prior authorization is also required for nonemergency inpatient mental health, psychoanalysis, and outpatient mental health.

Providers are encouraged to ask the beneficiary about OHI. Since OHI status can change at any time, it is important to obtain this information from the beneficiary on a routine basis, including from family members of activated Reserve Component members. If a beneficiary's OHI status changes, make sure to update patient billing system records to avoid delays in claim payments.

Submitting OHI Claims

The explanation of benefits (EOB) from the primary insurer must accompany your claim submission to PGBA if you are not able to transmit the required information on your electronic claim. Indicate the amount paid by the other insurer and include a copy of the primary insurer's EOB with TRICARE paper claims. The primary EOB must contain the following:

- The definition of any "reason codes" utilized by the primary payer to describe how the claim was processed, when applicable
- Information on the action taken by the primary payer for each specific date of service and charges, when applicable

Claims submitted without the above information will be denied.

TRICARE Prime Point-of-Service Option

Point-of-service (POS) cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. However, there is a statutory requirement that the beneficiary needs to have pre-authorization for nonemergency inpatient behavioral health care, adjunctive dental, and organ transplantation whether or not the beneficiary has OHI.

Computation of Payments

When OHI is involved, the provider of care may receive not more than the TRICARE allowable charge through payment by the OHI and TRICARE. Providers may not collect any amount from a beneficiary after payment of the claim unless TRICARE and the OHI combined have failed to pay the allowable charge (if network or accepting assignment) or the 115 percent of allowable charge (if not accepting assignment). In the case of a network provider, the contractually negotiated amount is the allowable charge.

TRICARE and Third Party Liability Insurance

The Federal Medical Recovery Act allows the government to be reimbursed for its costs of treating a TRICARE beneficiary if the beneficiary was injured in an accident caused by someone else. Humana Military is responsible for identifying and investigating all potential third party recovery claims. Claims submitted with diagnosis codes between 800 and 999 for outpatient services exceeding $500 and for all inpatient services often indicate an accidental injury or illness and will be pended for development. Pending for development means that the claim will not be processed further until the beneficiary completes a DD Form 2527 (Statement of Personal Injury–Possible Third Party).

There are certain diagnosis codes that are exceptions to the development criteria:

910.2-910.7	911.2-911.7
912.2-912.7	913.2-913.7
914.2-914.7	915.2-915.7
916.2-916.7	917.2-917.7
918.0	918.2
919.2-919.7	

When the claim is received and appears to have possible third party involvement as mentioned previously, the following will happen:

- The DD Form 2527 Statement of Personal Injury will be mailed to the beneficiary.
- The claim is pended for up to 35 calendar days. If the DD Form 2527 is not received, the claim will be denied.
- The claim will be reprocessed when the DD Form 2527 is completed and returned by the beneficiary. Encourage the beneficiary to fill out the form within the 35 calendar days to avoid payment delays.
- If the illness or injury was not caused by a third party, but the diagnosis code(s) still falls within 800 and 999, the beneficiary may still be responsible to fill out the form. If not returned, the claim will be denied.

TRICARE and Workers' Compensation

TRICARE will not cost-share work-related illnesses or injuries that are covered under workers' compensation programs.

TRICARE's Debt Collection Assistance Officer Program

Debt Collection Assistance Officers (DCAOs) are located at each TRICARE Regional Office and military treatment facility (MTF) to assist TRICARE beneficiaries in determining the validity of collection agent claims/negative credit reports received for debts incurred as a result of health care* under the TRICARE Program and will take all measures necessary to resolve the issues presented. Beneficiaries must bring or submit documentation associated with a collection action or adverse credit rating to the

DCAO. This includes debt collection letters, TRICARE EOBs, and health care bills from providers. The more information they can provide, the faster it will be to determine the cause of the problem. The DCAO will research their claim with the appropriate claims processor or other agency points of contact and provide them with a written resolution to their collection problem. The collection agency will be notified by the DCAO that action is being taken to resolve the issue.

The DCAO cannot provide beneficiaries with legal advice or fix their credit rating but can help them through the debt collection process by providing documentation that explains the circumstances relating to the debt to the collection or credit reporting agency. The DCAO directory is available online at www.tricare.osd.mil/DCAO.

**"Health care" includes medical and dental care under TRICARE.*

Medical Claim Reconsiderations

Claims appeals by providers on issues such as allowable charges, billing, and coding practices or non-covered benefits are reviewed by PGBA or Humana Military upon written request. Prepayment review of medical necessity or appropriate level of care is reviewed by Humana Military upon written request. Providers may request reconsideration within 90 days of the initial claim determination by PGBA at the following address:

TRICARE South Region
Appeals Department
P.O. Box 202002
Florence, SC 29502-2002

Notes

Notes

Details about how TRICARE determines reimbursement for health care services

TRICARE Reimbursement Methodologies

Reimbursement Limitations

Payments made to network providers for medical services to TRICARE beneficiaries shall not exceed 100 percent of the TRICARE allowable charges.

CHAMPUS Maximum Allowable Charge

The CHAMPUS maximum allowable charge (CMAC) is the maximum amount TRICARE will cover for nationally established fees (e.g., fees for professional services). CMAC is the TRICARE allowable charge for covered services when appropriately applied to services priced under CMAC. For more information, visit www.tricare.osd.mil/cmac.

TRICARE Allowable Charge

The term "allowable charge" is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The allowable charge is normally the lower of the actual billed charge and the allowable charge.

For example:

- If the allowable charge for a service is $90, and the billed charge is $50, TRICARE will pay $50 (actual billed charge).
- If the billed charge is $100, TRICARE will pay $90 (the allowable charge). In the case of inpatient hospital payments, the diagnosis-related group (DRG) is the TRICARE allowable charge regardless of the billed amount.

State Prevailing Rates

Prevailing rates are those that fall within the range of charges most frequently used in a state for a particular procedure or service. When no maximum allowable charge is available, a prevailing charge is developed for the state where the service or procedure is provided. The prevailing rate is based on the rate at the 80th percentile of the total number of charges within that state.

Anesthesia Rates

TRICARE reimbursement of anesthesia services is calculated using the number of time units, the Medicare relative value units, and the anesthesia conversion factor. For more information about anesthesia reimbursement, see details noted below.

Anesthesia Claims and Reimbursement

Professional anesthesia claims must be submitted on an appropriate CMS-1500 form, using current (Physicians') Current Procedural Coding (CPT) anesthesia codes (00100-01999) and the appropriate physical status (P) modifier. The use of other optional modifiers may also be appropriate. An anesthesia claim must specify who provided the anesthesia. In cases where a portion of the anesthesia service is provided by an anesthesiologist and a nurse anesthetist performs the remainder, the claim must identify exactly which services were provided by each. It is not appropriate to include revenue codes on a professional anesthesia claim.

Calculating Anesthesia Reimbursement

The following formula is used to calculate the TRICARE anesthesia reimbursement:

(Time Units + Relative Value Units) x Conversion Factor

Base Unit—TRICARE anesthesia reimbursement is determined by calculating a base unit, derived from the Medicare Anesthesia Relative Value Guide, plus an amount for each unit of time the anesthesiologist is in attendance (in the presence of the beneficiary). A base unit includes reimbursement for:

- Preoperative examination of the beneficiary
- Administration of fluids and/or blood products incident to the anesthesia care
- Interpretation of non-invasive monitoring (e.g., electrocardiogram, temperature, blood pressure, oximetry, capnography, and mass spectrometry)

- Determining the required dosage/method of anesthesia
- Induction of anesthesia
- Follow-up care for possible post operative effects of anesthesia on the beneficiary

Placement of arterial, central venous, and pulmonary artery catheters, and use of transesophageal echocardiography are not included in the base unit value. When multiple surgeries are performed, only the relative value units (RVUs) for the primary surgical procedure are considered, while the time units should include the entire surgical session. **Note:** This does not apply to continuous epidural analgesia.

Time Unit—Time units are determined in increments of 15 minutes. Any fraction of a unit is considered a whole unit. Anesthesia time starts when the anesthesiologist begins to prepare the beneficiary for anesthesia care in the operating room or in an equivalent area. It ends when the anesthesiologist is no longer in personal attendance and the beneficiary may be safely placed under post-anesthesia supervision. Providers may indicate the number of time units in the Days, Units, or Time box of the claim form.

Conversion Factor—The sum of the time units and RVUs is multiplied by a conversion factor. Conversion factors differ between physician and non-physician providers and vary by state, based on local wage indexes.

For more specific information on anesthesia reimbursement calculation and methodologies, please see the TRICARE Reimbursement Manual online at www.tricare.osd.mil/tricaremanuals.

Ambulatory Surgery Grouper Rates

Ambulatory surgery facility charges fall into one of 11 TRICARE grouper rates. TRICARE payment rates established under this system apply only to the facility charges for ambulatory surgery. For more information about ambulatory surgery coverage by TRICARE, see the detailed information below.

Ambulatory Surgery Center Charges

Ambulatory surgery center (ASC) claims may be submitted for TRICARE-approved ASC procedures on a UB-92. Only outpatient hospital ASC charges may be submitted on the 837 transaction (electronic version of the CMS-1500). The surgery grouper (SG) modifier should be indicated on the form.

ASC Reimbursement Inside/Outside of Grouper

All procedures are approved on the basis of medical necessity. The following updated revenue codes are paid the ASC grouper facility fee:

The following codes are payable **outside** the grouper when billed on the same claim or on a separate claim for the same date and place of service:

For additional information, network ambulatory surgery providers may contact their network representative.

Multiple Procedures

When all procedures performed are on the approved list, multiple ambulatory surgeries are processed according to multiple surgery guidelines. Reimbursement is the lower of:

- The total billed charges for all procedures performed
- The sum of 100 percent of the allowable charges for the primary surgical procedure (i.e., the procedure with the higher allowable charge), plus 50 percent of the allowable charge for all other covered surgical procedures

When surgical procedures involve fingers, toes, excision or biopsies of multiple lesions, reimbursement will be based on the CPT guidelines for multiple surgical procedures according to the following percentages:

- 100 percent of the allowable charge for the first procedure
- 50 percent of the allowable charge for the second procedure
- 25 percent of the allowable charge for the third and all subsequent procedures

No reimbursement is made for incidental procedures performed during the same operative session in which other covered surgical procedures were performed. In some instances of multiple ambulatory surgeries, one procedure is on the approved list and one is not. PGBA (Humana Military's claims processing partner) processes the charges for the procedure on the approved list under the ambulatory surgery guidelines. The procedure on the approved list is reimbursed as described previously. Facility charges for procedures that are not on the approved list are reimbursed at the TRICARE allowable charge, billed charge, or negotiated rate appropriate for the procedure performed.

Diagnosis-Related Group Reimbursement

This is a reimbursement system for inpatient charges from facilities, which assign payment levels to each diagnosis-related group (DRG), based on the average cost of treating all TRICARE beneficiaries in a given DRG. TRICARE payment rates, DRG weights, and wage indexes for calculating DRG-based payments are modeled on the Medicare prospective payment system (PPS). Cases are classified into the appropriate DRG by a grouper program.

Refer to the TRICARE Reimbursement Manual on the TRICARE's Web site at www.tricare.osd.mil/tricaremanuals for detailed information.

Durable Medical Equipment Pricing

Most durable medical equipment (DME) for the TRICARE South Region is priced using state prevailing rates.

Skilled Nursing Facility Pricing

Skilled nursing facilities (SNFs) are paid using the Medicare PPS. SNF admissions on or after August 1, 2003, require an authorization when TRICARE is the primary payer. Children under age 10 and critical access hospital (CAH) swing beds are exempt from this consolidate pricing under SNF PPS. For additional details on SNF PPS, please visit www.tricare.osd.mil/tricaremanuals.

Home Health Agency Prospective Payment System

Upon transition to the TRICARE South Region contract, providers will be reimbursed for home health services using the Medicare PPS. Home Health benefits subject to home health agency (HHA) consolidated billing must be managed by a primary HHA who has authorization for the patient's 60-day episode of care. For additional details on HHA PPS, please visit www.tricare.osd.mil/tricaremanuals.

Updates to TRICARE Rates and Weights

Reimbursement rates and methodologies are subject to change per Department of Defense guidelines. TRICARE rates are subject to change on at least an annual basis. Annual rate changes are usually effective on the following dates:

Date	Rates Scheduled to Change
February 1	CMAC Anesthesia Birthing Centers
October 1	DRG Residential Treatment Centers Mental Health Per Diem SNF PPS
November 1	Ambulatory Surgery Grouper
Quarterly (January, April, July, October)	Home Health PPS

Visit www.tricare.osd.mil/provider for more information about TRICARE reimbursement methodologies.

Notes

Additional resources to assist you in understanding TRICARE and doing your job

Provider Tools

Advance Directives

It is best to ask a patient early on in his/her care if he/she has a living will or other form of advance directive. Not only does this information get included in the patient's chart, but by raising the issue, the patient has an opportunity to clarify his/her wishes with the care providers and his/her family. However, advance directives take effect only in situations where a patient is unable to participate directly in medical decision making. Appeals to living wills and surrogate decision makers are ethically and legally inappropriate when individuals remain competent to guide their own care. The assessment of decisional incapacity is often difficult and may involve a psychiatric evaluation and, at times, a legal determination.

Some directives are written to apply only in particular clinical situations, such as when the patient has a "terminal" condition or an "incurable" illness. These ambiguous terms mean that directives must be interpreted by caregivers. More recent forms of instructive directives have attempted to overcome this ambiguity by addressing specific interventions (e.g., blood transfusions or CPR) that are to be prohibited in all clinical contexts.

What if a patient changes his/her mind?

As long as a patient remains competent to participate in medical decisions, both documents are revocable. Informed decisions by competent patients always supercede any written directive.

What if the family disagrees with a patient's living will?

If there is a disagreement about either the interpretation or the authority of a patient's living will, the medical team should meet with the family and clarify what is at issue. The team should explore the family's rationale for disagreeing with the living will. Do they have a different idea of what should be done? Do they have a different impression of what would be in the patient's best interests given his/her values and commitments? Or does the family disagree with the physician's interpretation of the living will? These are complex and sensitive situations, and a careful dialogue can usually identify many other fears and concerns. However, if the family merely does not like what the patient has requested, they do not have much ethical power to sway the team. If the disagreement is based on new knowledge, substituted judgment, or recognition that the medical team has misinterpreted the living will, the family has much more say in the situation. If no agreement is reached, the hospital's Ethics Committee should be consulted.

How should I interpret a patient's advance directive?

Living wills generally are written in ambiguous terms and demand interpretation by providers. Terms like "extraordinary means" and "unnaturally prolonging my life" need to be placed in context of the patient's values in order to be meaningfully understood. More recent forms of instructive directives have attempted to overcome this ambiguity by addressing specific interventions (e.g., blood transfusions or CPR) to be withheld. The Durable Power of Attorney for Health Care or a close family member often can help the care team reach an understanding about what the patient would have wanted. Of course, physician-patient dialogue is the best guide for developing a personalized advance directive.

What are the limitations of living wills?

Living wills cannot cover all conceivable end-of-life decisions. There is too much variability in clinical decision making to make an all-encompassing living will possible. Persons who have written or are considering writing advance directives should be made aware of the fact that these documents are insufficient to ensure that all decisions regarding care at the end of life will be made in accordance with their written wishes. They should be strongly encouraged to communicate preferences and values to both their medical providers and family or surrogate decision makers.

Another potential limitation of advance directives is possible changes in the patient's

preferences over time or circumstance. A living will may become inconsistent with the patient's revised views about quality of life or other outcomes. This is yet another reason to recommend that patients communicate with their physicians and family members about their end-of-life wishes.

Acronyms

AD	Active Duty
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AGR	Active Guard/Reserve
ASC	Ambulatory Surgery Center
BCAC	Beneficiary Counseling and Assistance Coordinators
BCF	Basic Core Formulary
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (now called TRICARE)
CHAMPVA	Civilian Health and Medical Program of the Veterans Affairs (Veterans Affairs health care program for Medicare-eligible beneficiaries)
CHCBP	Continued Health Care Benefit Program
CMAC	CHAMPUS Maximum Allowable Charge
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)
COB	Coordination of Benefits
COE	Centers of Excellence
CONUS	Continental United States
CPT	[Physician's] Current Procedural Terminology
CT	Computerized Tomography
DCAO	Debt Collections Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DHHS	Department of Health and Human Services
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DoD	Department of Defense
DOS	Date of Service
DRG	Diagnosis-Related Group
DSO	Defense Manpower Data Center (DMDC) Support Office
DTF	Dental Treatment Facility
DVA	Department of Veterans Affairs
ECT	Electroconvulsive Therapy
EFT	Electronic Funds Transfer
EIN	Employee Identification Number
EMC	Electronic Media Claims
EOB	Explanation of Benefits
EOI	Evidence of Insurability
ESRD	End-Stage Renal Disease
ERA	Electronic Remittance Advice
FAQ	Frequently Asked Questions
FDA	Food and Drug Administration
HBA	Health Benefits Advisor
HCF	Health Care Finder
HCFA	Health Care Financing Administration (now CMS)
HCPCS	Health Care Procedure Coding System
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMHS	Humana Military Healthcare Services
HMO	Health Maintenance Organization
ICD-9	9th International Congress in Diagnosis Codes
ID	Identification
IRR	Individual Ready Reserve
IV	Intravenous
IVR	Interactive Voice Response
LMHC	Licensed Mental Health Counselor
LPC	Licensed Professional Counselor
MCSC	Managed Care Support Contractor
MHS	Military Health System
MMSO	Military Medical Support Office
MRI	Magnetic Resonance Imaging

MTF	Military Treatment Facility
NAS	Nonavailability Statement
NATO	North Atlantic Treaty Organization
NCI	National Cancer Institute
NCQA	National Committee for Quality Assurance
NDAA	National Defense Authorization Act
NG	National Guard
NOAA	National Oceanic and Atmospheric Administration
NQMC	National Quality Monitoring Contractor
OCONUS	Outside the Continental United States (Overseas)
ODTF	Overseas Dental Treatment Facility
OHI	Other Health Insurance
OTC	Over-the-Counter
OTR	Outpatient Treatment Request
P&T	Pharmacy and Therapeutics
PCM	Primary Care Manager
PCP	Primary Care Physician
PDTS	Pharmacy Data Transaction Service
PFP	Partners for Peace
PFPWD	Program for Persons with Disabilities
PGBA	PGBA, LLC
PHP	Partial Hospitalization Program
PHS	Public Health Service
POC	Point of Contact
POS	Point-of-Service
PPO	Preferred Provider Organization (TRICARE Extra)
QA	Quality Assurance
RC	Reserve Component
RDP	Remote Dental Program
RTC	Residential Treatment Center
SHCP	Supplemental Health Care Program
SNF	Skilled Nursing Facility
SPOC	Service Point of Contact
SSN	Social Security Number
SUDRF	Substance Use Disorder Rehabilitation Facility
TAMP	Transitional Assistance Management Program
TDEFIC	TRICARE Dual-Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program
TFL	TRICARE For Life
THCDP	Transitional Health Care Demonstration Project
THCB	Transitional Health Care Benefit
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOL	TRICARE Online
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TRDP	TRICARE Retiree Dental Program
TRO	TRICARE Regional Office
TRRx	TRICARE Retail Pharmacy Program
TSC	TRICARE Service Center
TSO	TRICARE Support Office
U.S.	United States
U.S.C.	United States Code
UCCI	United Concordia Companies, Inc.
USFHP	Uniformed Services Family Health Plan
USPHS	United States Public Health Service
VA	Department of Veterans Affairs, short for DVA
WIC	Women, Infants, and Children
WPS	Wisconsin Physicians Service

Glossary of Terms

Abuse

The improper or excessive use of program benefits, resources, or services by providers or beneficiaries. Abuse can be either intentional or unintentional and can occur when:

- Excessive or unnecessary services are used.
- Services are not appropriate for the beneficiary's condition.
- A beneficiary uses an expired or voided identification card.
- A more expensive treatment is rendered when a less expensive treatment would be as effective.
- A provider or beneficiary files false or incorrect claims.

and/or

- Billing or charging does not conform to TRICARE requirements.

Accepting Assignment

An accepting assignment is when a provider agrees to accept the TRICARE allowable charge(s), less any beneficiary cost-shares, copayments, or deductibles, as the full fee for care.

Allowable Charge, also TRICARE Allowable Charge

The term "allowable charge" is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The allowable charge is normally the lowest of the actual billed charge or the allowable charge. For example, if the allowable charge for a service is $90, and the billed charge is $50, TRICARE will pay $50 (actual billed charge); if the billed charge is $100, TRICARE will pay $90 (the allowable charge). In the case of inpatient hospital payments, the diagnosis-related group (DRG) is the TRICARE allowable charge of the billed amount regardless. This is also known as participating on a claim. For network providers, the allowable charge is the negotiated rate.

Allowable Charge Review

An allowable charge review is a method by which a network provider may request a review of a claim he/she deems was paid at an inappropriate level.

Authorization

A review determination made by a licensed professional nurse or other health care professional for requested services, procedures, or admissions. Authorizations must be obtained prior to services being rendered.

Authorized Provider

An authorized provider is a hospital or institutional provider, a physician or other individual professional provider, or other provider of services or supplies who meets the licensing and certification requirements of TRICARE in 32 CFR 199.6 and is practicing within the scope of that license. Any physician listed in 32 CFR 199.6 who holds a valid license to practice medicine in the state where he/she practices shall be an authorized provider. Providers not specifically listed in 32 CFR 199.6 are not considered authorized providers unless they are included in a TRICARE demonstration project.

Balance Billing

A term used to describe when a provider bills a beneficiary for the rest of the charges (the "balance" of the charges not to exceed 15 percent of the allowable charge for non-network providers, or not to exceed the negotiated rate for network providers), after TRICARE (and other health insurance) has paid everything it's going to pay. Network providers are prohibited from balance billing.

Beneficiary

A person who is eligible for TRICARE benefits.

Beneficiary Counseling and Assistance Coordinators (BCACs)

Persons at military treatment facilities (MTFs) who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors or HBAs.

BRAC Site

A military base that has been closed or targeted for closure by the Government's Base Realignment and Closure Commission (BRAC).

Care Coordination

An approach to care management using proactive methods to optimize health outcomes and reduce risks of future complications over a short-term (two to six weeks) single episode of care. Prospective and concurrent reviews are used to identify current and future beneficiary needs.

Case Management

A collaborative process normally associated with multiple episodes of health care intervention that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet a beneficiary's complex health needs. This is accomplished through communication and available resources that promote quality, cost-effective outcomes.

Catastrophic Cap

The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (October 1–September 30). The catastrophic cap for active duty families is $1,000, and the catastrophic cap for all other TRICARE eligible families is $3,000.

Centers for Medicare and Medicaid Services (CMS)

The Federal agency that oversees all aspects of health care claims filing for Medicare (formerly known as the Health Care Financing Administration or HCFA).

Certified Provider

A hospital or institutional provider, physician, or other individual professional provider of services or supplies specifically authorized by 32 CFR 199.6. Certified providers have been verified by TRICARE Management Activity (TMA) or Humana Military to meet the standards of 32 CFR 199.6 and have been approved to provide services to TRICARE beneficiaries and receive government payment for services rendered to TRICARE beneficiaries.

CHAMPUS Maximum Allowable Charge

The maximum amount TRICARE will cover for nationally established fees (i.e. fees for professional services). CMAC is the TRICARE allowable charge for covered services when appropriately applied to services priced under CMAC.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

The former health care program established to provide health coverage for active duty family members (ADFMs), retirees and their family members. TRICARE was organized as a separate office under the Assistant Secretary of Defense and replaced CHAMPUS in 1994. Benefits covered under CHAMPUS are now covered under TRICARE Standard.

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)

A federal health benefits program for family members of 100-percent totally and permanently disabled veterans. CHAMPVA is administered by the Department of Veterans Affairs and is not associated with the TRICARE program. For questions regarding CHAMPVA, call 1-800-733-8387 or 1-303-331-7599.

Circumvention
A term used to describe inappropriate medical practices or actions that result in unnecessary multiple admissions of an individual.

ClaimCheck®
A customized, automated claims auditing system that verifies the clinical accuracy of professional claims.

CMS-1500
Formerly known as the HCFA-1500, the CMS has changed the name of its claim form to CMS-1500. Providers may continue to use HCFA-1500 forms they already have in stock, but will be required to order CMS-1500 forms when their supplies are exhausted. The form itself has not changed.

Concurrent Review
A review performed during the course of a beneficiary's inpatient admission with the purpose of validating the appropriateness of the admission, level of care, medical necessity, and quality of care, as well as the information provided during earlier reviews. Additional functions performed include screening for case management and identification of discharge planning needs. The review may be conducted by telephone or on-site. Concurrent reviews are generally performed when TRICARE is the primary insurer. Concurrent reviews that indicate criteria are not met are referred for physician review.

Copayment
The fixed amount a TRICARE Prime enrollee will pay for care in the civilian provider network. Active duty family members (ADFMs) are not required to make copayments.

Cost-Share
The percentage of the allowable charges a beneficiary will pay under TRICARE Extra and TRICARE Standard. The cost-share depends on the sponsor's status—active duty or retired.

Credentialing
The process that evaluates and subsequently allows providers to participate in the TRICARE network. This includes a review of the provider's training, educational degrees, licensure, practice history, etc.

Current Procedural Terminology (CPT)
A systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified.

Deductible
The annual amount a TRICARE Extra or TRICARE Standard beneficiary must pay for covered outpatient benefits before TRICARE begins to share costs. TRICARE Prime beneficiaries do not have an annual deductible, unless they are utilizing their point-of-service (POS) option.

Defense Enrollment Eligibility Reporting System (DEERS)
A system operated by the Department of Defense and used by TRICARE contractors to determine and confirm the eligibility of beneficiaries. Beneficiaries are responsible for maintaining the accuracy of their DEERS records and updating the system as necessary.

Diagnosis-Related Group (DRG)
A reimbursement methodology used for inpatient care in some hospitals.

Discharge Planning
A process that assesses requirements and the coordination of care for a beneficiary's timely discharge from an acute inpatient setting to a post-care environment without need for additional military treatment facility (MTF) or civilian provider assistance.

Disease Management
A prospective, disease-specific approach to improving health care outcomes by providing education to beneficiaries through non-physician practitioners who specialize in targeted diseases.

Enrollee
A TRICARE beneficiary who has elected to enroll in TRICARE Prime, TRICARE Prime Remote (TPR), or TRICARE Prime Remote for Active Duty Family Members (TPRADFM).

Explanation of Benefits (EOB)
A statement sent to beneficiaries showing that claims were processed and the amount paid to providers. If denied, an explanation of denial is provided.

Express Scripts, Inc.
The contractor responsible for providing a national network of civilian retail pharmacies for the TRICARE Retail Pharmacy Program, as well as for administering the national TRICARE Mail Order Pharmacy (TMOP) program (www.express-scripts.com).

Foreign Identification Number (FIN)
A permanent identification number assigned to a North Atlantic Treaty Organization (NATO) beneficiary by the appropriate national embassy. The number resembles a Social Security number (SSN) and most often starts with six or nine. TRICARE will not issue an authorization for treatment or services to NATO beneficiaries without a valid FIN.

Fraud
An instance in which deliberate deceit is used by a provider to obtain payment for services not actually delivered or received, or by a beneficiary to claim program eligibility.

Health Care Financing Administration (HCFA)
The former name of the Centers for Medicare and Medicaid Services or CMS.

Health Care Finder (HCF)
An individual located at TRICARE offices who assists beneficiaries in the coordination of referrals.

Health Care Procedural Coding System (HCPCS)
A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes for services not included in the normal CPT code list, such as durable medical equipment and ambulance service. While HCPCS is nationally defined, there is a provision for local use of certain codes.

HIPAA
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was introduced to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes.

Health Management Strategic International (HMSI)
A company that has developed behavioral health review criteria for medical necessity reviews.

Initial Denial
Made only after second-level review if the care or treatment is not found to be medically necessary, reasonable, or at the appropriate level. The non-network, participating provider or beneficiary may request a reconsideration of the initial denial. See “Second-level Review” for clarification.

Managed Care
A concept under which an organization delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of health care.

Managed Care Support Contractor (MCSC)
The Military Health System's (MHS') civilian health care partners who administer TRICARE in each of the TRICARE regions.

Medical Emergency
A medical condition manifesting itself by "acute symptoms of sufficient severity—including severe pain—such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." In the case of a pregnant woman, the danger should be considered to adversely affect the health of the woman or her unborn child. A provider qualified to furnish emergency services and those needed to evaluate or stabilize an emergency medical condition must furnish inpatient or outpatient emergency services.

Medically Necessary
Appropriate and necessary treatment of the beneficiary's illness or injury according to accepted standards of medical practice and TRICARE policy. Medical necessity must be documented in clinical notes.

Military Treatment Facility (MTF)
A medical facility operated by the military that may provide inpatient and/or ambulatory care to eligible TRICARE beneficiaries. MTF capabilities vary from limited acute care clinics to teaching and tertiary care medical centers.

Network Provider
A network provider is one who serves TRICARE beneficiaries by agreement with the MCSC as a member of the TRICARE Prime network or any other preferred provider network or by any other contractual agreement with the MCSC. A network provider accepts the negotiated rate as payment in full for services rendered.

Nonavailability Statement (NAS)
A certification from an MTF that a specific health care service or procedure cannot be provided.

Non-network Provider
A non-network provider is one who has no contractual relationship with the MCSC to provide care to TRICARE beneficiaries, but is certified to provide care to TRICARE beneficiaries. A non-network provider must be authorized. There are two types of non-network providers—"participating" and "nonparticipating."

Nonparticipating Provider
A nonparticipating provider is a certified hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to TRICARE beneficiaries, but who has not signed a contract and does not agree to "accept assignment."

North Atlantic Treaty Organization (NATO) Member
A member of a foreign NATO nation's armed forces who is on active duty and who, in connection with official duties, is stationed in or passing through the U.S. The foreign NATO nations are Belgium, Canada, Czech Republic, Denmark, France, Federal Republic of Germany, Greece, Hungary, Iceland, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Spain, Turkey, and the United Kingdom.

Other Health Insurance (OHI)
Any non-TRICARE health insurance that is not considered a supplement. This insurance is acquired through an employer, entitlement program, or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, or other programs or plans as identified by TRICARE Management Activity (TMA).

Participating Provider
Providers who participate in TRICARE, also called "accepting assignment," and who agree to accept the TRICARE-determined allowable cost or charge as the total charge for services—also known as the TRICARE allowable charge as the full fee for care. In the case of network providers, the negotiated rate is considered the full fee for care. Non-network, individual providers may participate on a case-by-case basis. Providers may seek applicable copayments, cost-shares, and deductibles from the beneficiary. Hospitals that participate in Medicare must, by law, also participate in TRICARE for inpatient care. For outpatient care, they may or may not participate.

Peer Review Organization (PRO)
An organization charged with reviewing provider quality and medical necessity.

Per Diem
A reimbursement methodology based on a per-day rate that is currently used for behavioral health institutions and partial hospitalization programs.

Point of Service (POS)
An option that allows a TRICARE Prime beneficiary to obtain medically necessary services—inside or outside the network—from someone other than his/her primary care manager, without first obtaining a referral or authorization. Utilizing the POS option results in a deductible and greater out-of-pocket expenses for the beneficiary.

Pre-Authorization
See the definition for Prior Authorization.

Preferred Provider Organization (PPO)
A network of health care providers who provide services to patients at discounted rates or cost-shares. TRICARE Extra is considered to be a Preferred Provider Organization option.

Primary Care Manager (PCM)
A TRICARE civilian network provider or military treatment facility provider who provides primary care services to TRICARE beneficiaries*. A PCM is either selected by the beneficiary or assigned by a military treatment facility commander or his/her designated appointee. To the extent consistent with governing state rules and regulations, PCMs can include internists, family practitioners, pediatricians, general practitioners, obstetricians, obstetrician/gynecologists, physician assistants, nurse practitioners, or certified nurse midwives. (*TRICARE Prime Remote beneficiaries may choose a TRICARE certified provider if a network provider is not available.)

Prime Service Area
Formerly called catchment area and defined to be within a 40-mile radius (determined by ZIP code) of a military treatment facility (MTF). It now also includes areas containing a high concentration of TRICARE beneficiaries and who are not within the catchment area of an MTF. The MCSC is required to offer TRICARE Prime in each prime service area.

Prior Authorization
A review determination made by a licensed professional nurse or paraprofessional for requested services, procedures, or admissions. Prior authorizations must be obtained prior to services being rendered or within 24 hours of an admission.

Prospective Review
A screening process used to evaluate the medical necessity and appropriateness of a treatment or service proposed. The review is prospective (before the care or service is performed) and criteria-based. A registered nurse, physician assistant, behavioral health clinician or physician performs reviews. A first-level (i.e., prospective) review may result in an authorization of services or in a referral to second-level review. A prospective review never results in a denial of care or treatment.

Reconsideration or Appeal
A formal written request by an appropriate appealing party or an appointed representative to resolve a disputed statement of fact.

Referral
The process by which a PCM refers a TRICARE Prime beneficiary to another professional or ancillary provider for specialized medical services, prior to those services being rendered. The MCSC must approve referrals.

Region
A geographic area determined by the Federal Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Remittance Advice
A statement sent to providers showing that claims were processed and the amount for which the beneficiary is responsible. If denied, an explanation of denial is provided.

Reserve Component
The Reserve Component includes the Army National Guard, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the U.S. Coast Guard Reserve.

Resource Sharing Agreement (RSA)
There are two types of RSAs. External RSAs are arrangements that allow military providers to render medical services to TRICARE beneficiaries in civilian network medical facilities. Internal RSAs are arrangements that allow civilian providers into the MTF system to render medical services to TRICARE beneficiaries.

Retrospective Review
A review of a beneficiary's medical record that occurs after the services have been rendered.

Second-level Review
Cases that do not meet the prospective review screening criteria are referred for physician review at the second level.

Split Enrollment
Refers to multiple family members enrolled in TRICARE Prime under different TRICARE regions or MCSCs.

Sponsor
The active duty service member or retiree through whom family members are eligible for TRICARE.

Supplemental Insurance
Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) plans, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

Tax Identification Number
A tax identification number is a number assigned by the State in which a business or entity is operated that identifies it for filing and paying taxes related to the business or entity.

Treatment Plan
A treatment plan is a multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, military resources, all funding options, treatment goals, and assessment of the beneficiary environment. The plan is updated monthly and modified when appropriate. These plans are developed in collaboration with the attending physician and beneficiary or guardian.

Sample Identification Cards

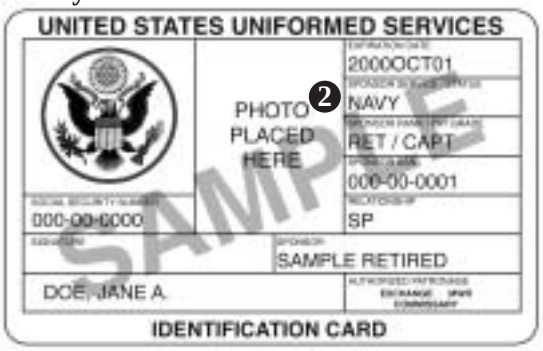
Uniformed Services Identification Cards

The uniformed services identification (ID) card is credit card sized and incorporates a digital photograph image of the bearer, bar codes containing pertinent machine-readable data, and printed identification and entitlement information. The beneficiary category determines the ID card's color:

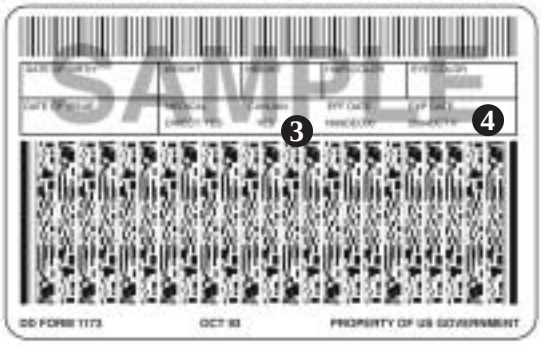
- Active duty service members—green
- Active duty family members—tan
- Members of the Reserve Component and their eligible family members—red
- Retirees—blue
- Retiree family members—tan

Sponsor Card

Family Member Card



Back of Cards



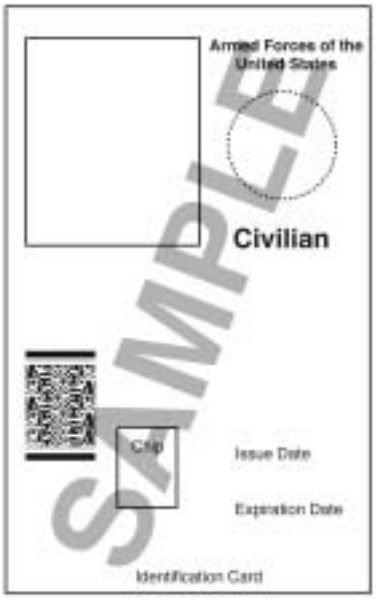
1. Rank and Pay Grade: Indicates rank and pay grade of the sponsor.
2. Sponsor Status: Indicates the sponsor's status (active duty or retired—should say "INDEF" for retirees).
3. Eligibility: Check the back of the ID card to verify eligibility for TRICARE. The center section should say, "YES" under the box titled, "CIVILIAN." If a beneficiary using TRICARE For Life (TFL) has an ID card that says "NO" in this block, they are still eligible to use TFL if they are enrolled in Medicare Part B.
4. Expiration Date: Check the expiration date on the ID card in the box titled, "EXP DATE." If expired, the beneficiary will need to update their information in the Defense Enrollment Eligibility Reporting System (DEERS) and get a new card.

Beneficiaries under the age of 10 are not routinely issued ID cards, so the parent's ID card may serve as proof of eligibility.

The Department of Defense (DoD), in conjunction with the seven uniformed services, began issuing this style of identification (ID) card in 1994. The Common Access Card (CAC) is replacing this style and is being phased in over the next few years. Please honor these cards. They are valid uniformed services ID cards.

Common Access Card

The Common Access Card (CAC) is replacing the current uniformed services ID card, described above. The following is an example of the new CAC.



Copying ID Cards

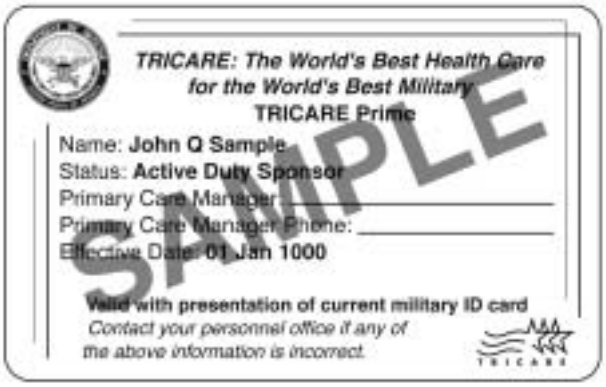
Military personnel and their family members may express concern about having their military ID cards photocopied, perhaps because they have always been instructed never to lose or allow someone to use their card. These instructions are designed to prevent identity theft and safeguard against security being compromised by someone impersonating U.S. military personnel.

Although some TRICARE beneficiaries may believe that its illegal to copy ID cards, it is in fact, legal to copy them for authorized purposes†. The legitimate cardholder may allow his/her military or uniformed services ID card to be photocopied to facilitate medical care eligibility determination and documentation, check cashing, or the administration or other military-related benefits. Per TMA instruction, it is both allowable and advisable for providers to copy the beneficiary's ID card for proof of eligibility and for the purpose of rendering needed services. TMA recommends that providers copy both sides of the ID cards and retain copies for future reference.

†Title, 18 USC, Section 701 prohibits photographing, or possessing uniformed services ID cards in an unauthorized manner. Unauthorized use would exist only if the bearer uses the card in a manner that would enable him/her to obtain benefits, privileges, or access to which he/she is not entitled.

TRICARE Prime Enrollment Card

Beneficiaries enrolled in TRICARE Prime, TRICARE Prime Remote (TPR), and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) receive TRICARE Prime enrollment cards. Network providers may require beneficiaries to show the card at the time of service. These cards are not required to obtain care, but do contain important information for the beneficiary. Only the uniformed services ID card or new CAC card may be used to verify eligibility for care.



Sample Forms

Samples of important TRICARE forms are illustrated on the following pages. To download these forms, visit www.humana-military.com

- **Health Insurance Claim Form**
- **Uniform Bill Form (UB-92)**
- **Statement of Personal Injury/Third Party Liability**
- **Patient Referral Authorization Form**
- **Other Health Insurance Questionnaire**

SAMPLE—Do not use.

Current form can be found at www.humana-military.com.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Health Insurance Claim Form, (instructions)

Claims must be submitted on the CMS-1500 for professional services. The following information is ***required*** on every claim:

BOX 1 Indicate that this is a TRICARE claim by checking the box under "CHAMPUS."

BOX 1A Sponsor's Social Security Number. The sponsor is the person that qualifies the patient for TRICARE benefits.

BOX 2 Patient's name

BOX 3 Patient's date of birth and sex

BOX 4 Sponsor's full name. Do not complete if "self " is checked in BOX 6.

BOX 5 Patient's address including ZIP code. This must be a physical address. Post office boxes are not acceptable.

BOX 6 Patient's relationship to sponsor

BOX 7 Sponsor's address including ZIP code

BOX 8 Marital and employment status of patient

Note: *Box 11D should be completed prior to determining the need for completing boxes 9A through 9D. If Box 11D is checked "yes", Boxes 9A and 9D must be completed. In addition, if there is another insurance carrier, the mailing address of that insurance carrier must be attached to the claim form.*

BOX 9 Full name of person with other health insurance (OHI) that covers patient

BOX 9A Other insured's policy or group number

BOX 9B Other insured's date of birth and sex (Not required, but preferred)

BOX 9C Other insured's employer name or name of school

BOX 9D Name of insurance plan or program name where individual has OHI

BOX 10A-C Check to indicate whether employment or accident related. (In the case of an auto accident, indicate where it occurred.)

Note: *Box 11 through Box 11C questions pertain to the sponsor.*

BOX 11 Indicate policy group or Federal Employees Compensation Act (FECA) number (if applicable).

BOX 11A Sponsor's date of birth and sex, if different than Box 3

BOX 11B Sponsor's branch of service

BOX 11C Indicate "TRICARE" in this field.

BOX 11D Indicate if there is another health insurance plan primary to TRICARE in this field.

BOX 12 Patient's or authorized person's signature and date; release of information. A signature on the file is acceptable provided signature is updated annually.

BOX 13 Insured's or Authorized Person's Signature. This authorizes payment to the physician or supplier.

BOX 14 Date of current illness or injury/ Date of pregnancy (Required for injury or pregnancy)

BOX 15 First date (MM/DD/YY) had same or similar illness (Not required, but preferred)

BOX 16 Dates patient unable to work (Not required, but preferred)

BOX 17 Name of referring physician (Very important to include this information)

BOX 17A Identification number of referring physician (Not required, but preferred)

BOX 18 Admit and discharge date of hospitalization

BOX 19 Referral number

BOX 20 Check if lab work was performed outside the physician's office and indicate charges by the lab. If an outside provider (e.g. laboratory) performs a service, claims should include modifier "90" or indicate "Yes" in this block.

BOX 21 Indicate at least one, and up to four, specific diagnosis codes.

BOX 23 Pre-authorization number

BOX 24A Date of service

BOX 24B Place of service

BOX 24C Type of service

BOX 24D	CPT/HCPC procedure code with modifier, if applicable
BOX 24E	Diagnosis code or related item number
BOX 24F	Charges for listed service
BOX 24G	Days or units for each line item
BOX 24J	Coordination of Benefits (COB)
BOX 24K	State license number of attending physician. If the service is performed in a clinic, provide the name and title of the person who administered care.
BOX 25	Physician's/Supplier's Tax Identification Number
BOX 26	Patient's Account Number (Not required, but preferred)
BOX 27	Indicate whether provider accepts TRICARE assignment.
BOX 28	Total charges submitted on claim
BOX 29	Amount paid by patient or other carrier
BOX 30	Amount due after other payments are applied (Required if OHI)
BOX 31	Authorized signature (If not entered in Box 24K, state license number)
BOX 32	Name and address where services were rendered. This must be the actual physical location. If you use an independent billing service, please do not use this address.
BOX 33	Physician's/Supplier's billing name, address, ZIP code and phone number

CMS-1500 Place of Service Codes

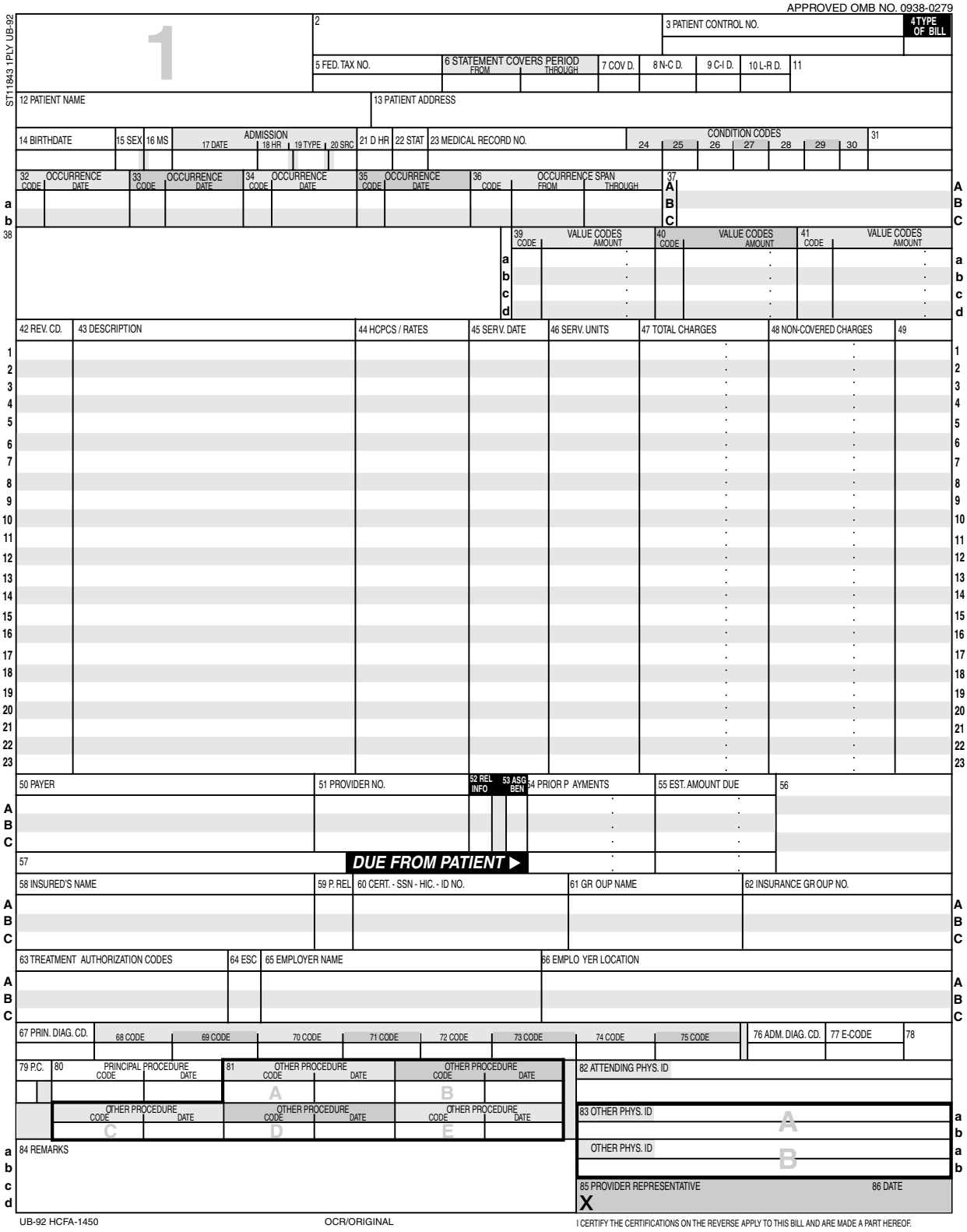
11	Office
12	Home
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room - hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility (MTF)
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance, land
42	Ambulance, air or water
51	Inpatient psychiatric facility
52	Psychiatric facility, partial hospitalization
53	Community mental health center
54	Intermediate care center/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory
99	Other unlisted facility

Type of Service Codes

1	Medical care
2	Surgery
3	Consultation
4	Diagnostic x-ray
5	Diagnostic laboratory
6	Radiation therapy
7	Anesthesia
8	Assistant at surgery
9	Other medical service
A	Durable Medical Equipment (DME) rental/purchase
B	Drugs
C	Ambulatory surgery
D	Hospice
E	Second opinion on elective surgery
F	Maternity
G	Dental
H	Mental health care
I	Ambulance
J	Program for Persons with Disabilities (PFPWD)

SAMPLE—Do not use.

Current form can be found at www.humana-military.com.



Uniform Bill Form (UB-92), page 2

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Uniform Bill Form (UB-92) (instructions)

The following listing of UB-92 form locators is a summary of the form locator information.

FL 1	Provider name, address and telephone number required. The minimum entry is the provider's name, address, city, state, and ZIP code. Telephone and/or fax numbers are also desired.
FL 2	Not required
FL 3	Patient Control Number
FL 4	Type of Bill (Three-digit alphanumeric number)
FL 5	Federal Tax Identification Number
FL 6	Statement Covers Period (From-Through). The beginning and ending dates of the period included on the bill are shown in numeric fields (MM-DD-YY).
FL 7	Not Required
FL 8	Not Required
FL 9	Not Required
FL 10	Not Required
FL 11	Not Required
FL 12	Patient's Name (Surname first, first name, and middle initial, if any)
FL 13	Patient's full address to include: state, city, street name and number, Post Office Box number, ZIP code and /or RFD
FL 14	Patient's Birthdate (MM-DD-YYYY). If the date of birth was not obtained after reasonable efforts by the provider, the field will be zero filled.
FL 15	Patient Sex. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.
FL 16	Patient's Marital Status
FL 17	Admission Date
FL 18	Admission Hour
FL 19	Type of Admission. This code indicates priority of the admission.
FL 20	Source of Admission. This code indicates the source of admission or outpatient registration.
FL 21	Discharge Hour
FL 22	Patient Status. This code indicates the patient's status as of the "Through" date of the billing period (FL 6).
FL 23	Medical Record Number
FLs 24-30	Condition Codes
FL 31	Not Required
FLs 32-35	Occurrence Codes and Dates
FL 36	Occurrence Span Code and Dates
FL 37	Not Required
FL 38	Not Required
FL 39-41	Value Codes and Amounts
FL 42	Revenue Code
FL 43	Revenue Description—A narrative description or standard abbreviation for each revenue code in FL 42. Descriptions or abbreviations correspond to the revenue codes.
FL 44	HCPCS/Rates. When coding HCPCS, enter the HCPCS code describing the procedure.
FL 45	Service Date. If submitting claims for outpatient services, report a separate date for each day of service.
FL 46	Service Units. The entries in this column quantify services by revenue category (e.g., number of days, a particular type of accommodation, pints of blood, etc.). Up to seven digits may be entered.
FL 47	Total Charges
FL 48	Non-covered Charges. The total non-covered charges pertaining to the related revenue code in FL 42 is entered here.
FL 49	Not Required
FL 50a,b,c	Payer Identification. Enter the primary payer on line A.
FL 51a,b,c	Provider Number
FL 52a,b,c	Release of Information. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.
FL 53a,b,c	Assignment of Benefits Certification Indicator
FL 54a,b,c	Prior Payments. For all services

other than inpatient hospital and Skilled Nursing Facility (SNF) services, the sum of any amount(s) collected by the provider from the patient toward deductibles and/or co-insurance are entered on the patient (fourth/last) line of this column.

FL 55a,b,c Not Required

FL 56 Not Required

FL 57 Not Required

FL 58a,b,c Insured's Name

FL 59a,b,c Patient's Relationship to Insured

FL 60a,b,c Certificate/Social Security Number/Health Insurance Claim/Identification Number

FL 61a,b,c Group Name. Indicate the name of the insurance group or plan.

FL 62a,b,c Insurance Group Number

FL 63 Treatment Authorization Code. Whenever Peer Review Organization (PRO) review is performed for outpatient/inpatient preadmission or preprocedure, the authorization number is required for all approved admissions or services.

FL 64 Employment Status Code. Enter the code which defines the employment status of the individual identified on line FL 58, if available.

FL 65 Employer Name. Name of the employer that provides health care coverage for the individual identified on FL 58.

FL 66 Employer Location. Enter the specific location (city, plant, etc.) of the employer of the individual identified on FL 58.

FL 67 Principal Diagnosis Code. HCFA only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in Department of Health and Human Services (DHHS) Publication Number (PHS) 89-1260 or HCFA approved errata supplements to this publication. Diagnosis codes must be full ICD-9-CM diagnosis codes, including all five digits where applicable.

FL 68-75 Other Diagnosis Codes

FL 76 Admitting Diagnosis. For inpatient hospital claims subject to Peer Review Organization (PRO) review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL 77 Not Required

FL 78 Not Required

FL 79 Procedure Coding Method

FL 80 Principal Procedure Code and Date. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis.

FL 81 Other Procedure Codes and Dates. The full ICD-9-CM, Volume 3, Procedure Codes, including all four digits where applicable, must be shown for up to five significant procedures other than the principal procedure (which is shown in FL 80). The date of each procedure is shown in the date portion of Item 81, as applicable (MM-DD-YY).

FL 82 Attending/Referring Physician ID. Providers must enter the Unique Physician Identification Number (UPIN) and name of the attending/referring physician on inpatient bills or the physician that requested outpatient services.

FL 83 Other Physician ID

FL 84 Remarks. Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements.

FL 85 Provider Representative Signature

FL 86 Date. This is the date the provider's representative signed the UB-92 form.

Condition Codes

02 Condition is employment related

03 Patient covered by insurance not reflected here

08	Beneficiary would not provide information concerning other insurance coverage
18	Maiden name retained
19	Child retains mother's name
31	Patient is student (full-time—day)
33	Patient is student (full-time—night)
34	Patient is student (part-time)
36	General Care Patient in a special unit
38	Semi-private room not available
39	Private room medically necessary
46	Non-availability statement on file
48	Psychiatric residential treatment centers for children and adolescents
55	Skilled Nursing Facility (SNF) bed not available
56	Medical appropriateness
60	Day outlier
61	Cost outlier
67	Beneficiary elects not to use life time reserve days
0A	TRICARE External Partnership Program
A2	Physically Handicapped Children's Program
A7	Induced abortion—danger to life
A8	Induced abortion—victim rape/incest
C1	Approved as billed
C2	Automatic approval as billed based on focused review
C3	Partial approval
C4	Admission/services denied
C5	Postpayment review applicable
C6	Admission pre-authorization
C7	Extended authorization

Occurrence Span Codes

01	Auto accident
02	No fault insurance involved—including auto accident/other
03	Accident/tort liability
04	Accident/employment related
05	Other accident
06	Crime victim
21	Date UR notice received
22	Date active care ended
24	Date insurance denied
25	Date benefits terminated by primary payer
26	Date Skilled Nursing Facility bed became available
27	Date of hospice certification or re-certification
28	Date comprehensive outpatient rehabilitation plan established or last reviewed
29	Date outpatient physical therapy plan established or last reviewed
30	Date outpatient speech pathology plan established or last reviewed
31	Date beneficiary notified of intent to bill (accommodations)
32	Date beneficiary notified of intent to bill (procedures or treatments)
33	First day of the Medicare Coordination Period for End Stage Renal Disease (ESRD) beneficiaries covered by Employer Group Health Plan (EGHP)

Value Codes and Amounts

01	Most common semi-private rate
02	Hospital has no semi-private rooms
05	Professional component included in charges and also billed separate to carrier
30	Preadmission testing
31	Patient liability amount
37	Pints of blood furnished
46	Number of grace days

SAMPLE—Do not use.

Current form can be found at www.tricare.osd.mil/claims.

STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY

CHAMPUS

Form Approved
OMS No. 0720-0003
Expires Jun 30, 2002

IF A PREADDRESSED ENVELOPE IS NOT ENCLOSED WITH THIS FORM, PLEASE RETURN YOUR COMPLETED FORM TO EITHER OF THESE LOCATIONS:

(1) THE CHAMPUS CLAIMS PROCESSOR WHO SENT YOU THE FORM; OR

(2) THE CHAMPUS CLAIMS PROCESSOR FOR THE STATE/COUNTRY IN WHICH YOU RECEIVED THE MEDICAL CARE (the Health Benefits Advisor at your nearest military installation can provide you with this address).

The public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0003), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22207-4307. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.
PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS.

PRIVACY ACT STATEMENT

AUTHORITY: 42 U.S.C. 2651-2653; 10 U.S.C. 1079, 1085, 1086 and 1092; E.O. 9397; 38 U.S.C. 613.

PRINCIPAL PURPOSE(S): To assist in determining possible third party liability for medical supplies and services claims under CHAMPUS. Information requested is used in reviewing claims to obtain additional information to determine proper liability of third parties for claims and to facilitate possible recovery by the United States for improperly paid claims.

ROUTINE USE(S): Information may be given to the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to members of Congress with the consent of the individual involved. Appropriate disclosures may be made to other Federal, state, local and/or foreign law enforcement agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in a claims processing delay and may result in denial of the claim.

INSTRUCTIONS

According to information submitted with your recent CHAMPUS claim, you were treated for an injury of some kind. Because the claim form does not include information about how you were injured, we are asking that you also complete this form. The Federal Medical Recovery Act, 42 U.S.C. 2651-2653, allows the Government to be reimbursed for its costs of treating you, if you were injured in an accident caused by someone else. The Government can often recover its costs from (1) the person who caused the accident or that person's insurance company; or (2) the owner of the property where the accident occurred or the owner's insurance company. The Government may also be able to recover its costs from (1) any insurance company which insures your family for hospital and medical expenses; or (2) your employer's Worker's Compensation or other insurance, if you were injured at work.

If you were not treated for an injury, please describe the circumstances of your treatment in the Remarks section on Page 1. If you were treated for an injury but do not believe that someone else caused your injury, please describe in detail the circumstances surrounding your injury in the Remarks section on Page 2. If you use the Remarks section for either of these purposes, you do not need to complete the rest of the form. However, be sure to sign and return it according to the other instructions you have received.

This form is to be completed by persons who have received medical care at Government expense or by a responsible family member. In cases of young children, this form should be completed by a parent or guardian.

Answer all questions in as much detail as possible. The information you provide may be of great help to the Government and to you in recovering from the person who caused your injuries. We suggest you retain a copy of this form for your own use. If injury resulted from an automobile accident, you must attach a copy of the official police report to this form and complete Sections I, IV, and V. If injury did not result from an automobile accident, complete Sections I, III, and V.

The words "None," "N/A," and "Unknown" should be inserted where appropriate.

Attach additional sheets where necessary to provide complete information.

Complete all items to the best of your knowledge. **BE SURE TO SIGN AND DATE THE FORM ON PAGE 4. RETURN IT WITHIN 10 DAYS.**

IMPORTANT

This information is requested solely for the purpose of processing your CHAMPUS reimbursement claim. It has no bearing on any legal action you may pursue as a result of your injury. All questions you may have regarding possible legal actions should be referred to an attorney. Do not execute a release or settle any personal injury claim you may have without notice to a military claims officer.

SAMPLE—Do not use.

Current form can be found at www.tricare.osd.mil/claims.

**STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY
CHAMPUS**

SECTION I - GENERAL INFORMATION

1. SPONSOR

a. SPONSOR'S NAME *(Last, First, Middle Initial)*	b. SSN

2. INJURED BENEFICIARY

a. INJURED BENEFICIARY'S NAME *(Last, First, Middle Initial)*	b. AGE	c. RELATIONSHIP TO SPONSOR *(X one)*
		☐ SELF ☐ NATURAL/ADOPTED CHILD ☐ STEPCHILD ☐ SPOUSE ☐ FORMER SPOUSE ☐ OTHER

d. HOME ADDRESS *(Street, Apartment Number, City, State, ZIP Code)*	e. SPONSOR'S ADDRESS *(If different from injured beneficiary's) (Street, Apartment Number, City, State, ZIP Code)*
TELEPHONE NO. *(Include Area Code)*	TELEPHONE NO. *(Include Area Code)*

SECTION II - REMARKS

3. USE THIS SECTION TO DESCRIBE IN YOUR OWN WORDS HOW YOU WERE INJURED.

SECTION III - NON-VEHICULAR ACCIDENTS

Complete if injuries did not result from a motor vehicle accident. If injuries resulted from a vehicular accident, go to Section IV.

4. LOCATION

a. SITE OF INJURY *(Street/Place, City, County, State)*	b. TIME *(Hour)* ☐ A.M. ☐ P.M.	c. DATE *(YYYYMMDD)*
d. NAME AND ADDRESS OF OWNER OF PROPERTY WHERE INJURY OCCURRED	e. NAME OF OCCUPANT OF PROPERTY *(If different from owner)*	

5. PERSONS INVOLVED

a. NAME *(Last, First, Middle Initial)*	b. *ADDRESS (Street, City, State, ZIP Code)* AND TELEPHONE NO. *(Include Area Code)*

SAMPLE—Do not use.

Current form can be found at www.tricare.osd.mil/claims.

SECTION III - NON-VEHICULAR ACCIDENTS *(Continued)*

6. WITNESSES

a. NAME *(Last, First, Middle Initial)*	b. ADDRESS *(Street, City, State, Zip Code)* AND TELEPHONE NO. *(Include Area Code)*

7. POLICE INVESTIGATION

a. WAS AN INVESTIGATION CONDUCTED? *(If Yes, state by whom (e.g., City/State Police, Sheriff's Dept.)*	b. WAS ANYONE ARRESTED OR CITED AS CAUSING THE ACCIDENT? *(If yes, give name and charge)*	c. DISPOSITION OF CASE *(e.g., dismissal, fine, jail sentence)*
☐ YES ☐ NO	☐ YES ☐ NO	

d. EXPLAIN IN YOUR OWN WORDS WHO WAS AT FAULT AND WHY

e. WERE OTHER FAMILY MEMBERS INJURED IN THE ACCIDENT? *(If Yes, give name(s) and relationship)*

☐ YES
☐ NO

f. WAS THE ACCIDENT WORK RELATED? *(If Yes, state circumstances)*

☐ YES
☐ NO

8. INSURANCE

a. INSURANCE COMPANY OF OWNER OF PROPERTY WHERE INJURY OCCURRED *(e.g., Homeowner's Insurance Company)*	b. INSURANCE COMPANY OF PERSON WHO CAUSED ACCIDENT *(If different from item 8a.)*	c. YOUR OWN INSURANCE COMPANY
(1) COMPANY NAME	(1) COMPANY NAME	(1) COMPANY NAME
(2) ADDRESS *(Include ZIP Code)*	(2) ADDRESS *(Include ZIP Code)*	(2) ADDRESS *(Include ZIP Code)*
(3) POLICY NUMBER	(3) POLICY NUMBER	(3) POLICY NUMBER
(4) AMOUNTS AND TYPES OF COVERAGE	(4) AMOUNTS AND TYPES OF COVERAGE	(4) AMOUNTS AND TYPES OF COVERAGE

SAMPLE—Do not use.

Current form can be found at www.tricare.osd.mil/claims.

SECTION IV - VEHICULAR ACCIDENT Attach a copy of the official police report to this form.

9. ADDITIONAL INFORMATION ON VEHICULAR ACCIDENT

a. INJURED BENEFICIARY'S AUTOMOBILE INSURANCE COMPANY	b. INSURANCE COMPANY'S ADDRESS *(Include ZIP Code)*
c. INSURANCE COMPANY TELEPHONE NO. *(Include Area Code)*	

d. POLICY NUMBER	e. AMOUNTS AND TYPE OF COVERAGE			
	(1) LIABILITY $	(2) MEDICAL PAYMENT $	(3) UNINSURED MOTORIST $	(4) NO FAULT $

f. WAS ACCIDENT REPORTED TO YOUR INSURANCE COMPANY? *(If No, explain)*	g. HAS YOUR INSURANCE COMPANY ASSIGNED A CLAIM OR FILE NUMBER? *(If Yes, provide number)*
☐ YES ☐ NO	☐ YES ☐ NO

h. WAS ACCIDENT WORK RELATED? *(If Yes, state circumstances)*

☐ YES
☐ NO

SECTION V - MISCELLANEOUS

10. GOVERNMENT HOSPITALIZATION. If you were hospitalized or expect to be hospitalized in a government hospital, complete the following:

a. NAME OF HOSPITAL	b. ADDRESS *(Include ZIP Code)*	c. DATES HOSPITALIZED *(YYYYMMDD)* FROM	TO	d. IS TREATMENT COMPLETED? *(X one)* YES	NO

11. YOUR ATTORNEY

a. ATTORNEY'S NAME	b. ADDRESS *(Street, City, State, ZIP Code)*
c. TELEPHONE NUMBER *(Include Area Code)*	

12. RELEASE STATEMENTS

a. HAVE YOU FURNISHED ANYONE OTHER THAN THE POLICE A STATEMENT AS TO WHAT HAPPENED? *(If Yes, to whom was it given?)*	b. HAVE YOU SIGNED ANY RELEASE OR WAIVER OF RIGHTS? *(If Yes, to whom was it given?)*
☐ YES ☐ NO	☐ YES ☐ NO
c. HAVE YOU RECEIVED ANY OFFER OF SETTLEMENT FOR YOUR INJURY? *(If Yes, from whom?)*	d. HAVE YOU ACCEPTED ANY SETTLEMENT? *(If Yes, from whom and how much?)*
☐ YES ☐ NO	☐ YES ☐ NO

SECTION VI - CERTIFICATION

13. I have completed this form and state that the information is true to the best of my knowledge and belief. Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States.

a. YOUR SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

SAMPLE—Do not use.

Current form can be found at www.humana-military.com.

PATIENT REFERRAL AUTHORIZATION FORM

TRICARE referrals should be submitted through www.humana-military.com (select 'Online Provider Services'). If you do not have internet connection in your office you may complete and submit this form by fax to 1-877-548-1547.

Referral is based on medical necessity, subject to TRICARE eligibility, and is not a guarantee of payment.

Authorization Number:_____

SECTION I: PATIENT INFORMATION:

Last Name:_____ First Name:_____ MI:____ DOB:_____

Address:_____ Phone: (home)_____ (work)_____

Sponsor's Name:_____ Sponsor's SSN_____

SECTION II: OTHER HEALTH INSURANCE:

Motor Vehicle Accident: ☐ Yes ☐ No Work Related Case: ☐ Yes ☐ No

Other Health Insurance: Policy Holder _____

Employer_____

Carrier Name _____ Carrier Phone Number: _____

Effective Date:_____ Policy ID # _____

If Medicare: HIC Number _____ Part A Effective Date: _____ Part B Effective Date: _____

SECTION III: PCM INFORMATION **REFERRAL TO:**

PCM Name: _____ Specialty:_____

Office Phone: _____ Provider Name: _____

Office Fax:_____ Address:_____

Contact Person: _____ Office Phone:_____

Office Fax:_____ Contact Person:_____ Fax:_____

PCM Signature _____ Date: _____

SECTION IV: REFERRAL INFORMATION:

☐ Consult Only Appointment or Beginning Date: _____

☐ Consult and Treat No. Expected Visits:_____ Diagnosis:_____

Requested Time Frame: From _____ To _____ ICD 9 Diagnosis Code: _____

☐ Surgical Intervention CPT Code:_____

Requested Services:_____ Other: _____

Clinical Information/Physician Assessment: (include history, treatment plan, lab results, or medications to support medical necessity)

_____

_____

_____

_____

_____

RELEASE OF MEDICAL RECORDS

'I authorize the release of medical information resulting from this referral and ancillary services to the providers shown on this form."

Beneficiary Signature _____ Date_____

The TRICARE Program is a nondiscriminatory program for TRICARE eligibles offered without regard to beneficiary age, race, religion, gender, rank, sponsor status, family size or personal income. TRICARE is the Military Health Plan administered in the South Region by Humana Military Healthcare Services.

PROPRIETARY TO HMHS, NOT TO BE DISCLOSED

3/04 TP34-2568

SAMPLE—Do not use.
Current form can be found at www.humana-military.com.

TRICARE OTHER HEALTH INSURANCE (OHI) COVERAGE QUESTIONNAIRE

Providers: Please provide this form to eligible beneficiaries

1 – General Information

TRICARE Sponsor Name: _____ **TRICARE Sponsor SSN:** _____

Do you or any of your family members currently have Other Health Insurance (OHI) coverage? ☐ Yes ☐ No

Have you or any of your family members had Other Health Insurance (OHI) coverage in the past 12 months? ☐ Yes ☐ No

If you answered yes to question 1 or 2 above, please complete the remainder of the form (duplicate form for multiple policies). Regardless of your answers above, please read and sign the form at the bottom and submit the form to the address or fax number below.

2 – Current OHI Status– Complete only if you or any of your family members currently have OHI.

Policy Holder Name: _____ Policy Number: _____ Group/Plan Number: _____

Name of Carrier: _____ Effective Date: _____ Expiration Date: _____

Carrier Address and Phone No: _____

Please indicate the type of coverage: ☐HMO/PPO ☐Medicare ☐Single ☐Group ☐Supplemental ☐Private ☐Medic aid/MediCal ☐Other: _____

Does this coverage include pharmacy benefits? ☐Yes ☐No Does this coverage provide any other benefit riders? ☐Yes ☐No

If Yes, please indicate which one(s): _____

Name of Covered Member:	**Member ID:**	**Date of Birth:**	**Sex:**	**Effective Date** (If different)	**Expiration Date** (if different)

3 – Prior OHI Status– Complete only if you or any of your family members have had OHI within the last 12 months, but do not have coverage now.

Policy Holder Name: _____ Policy Number: _____ Group/Plan Number: _____

Name of Carrier: _____ Effective Date: _____ Expiration Date: _____

Carrier Address and Phone No: _____

Please indicate the type of coverage: ☐HMO/PPO ☐Medicare ☐Single ☐Group ☐Supplemental ☐Private ☐Medic aid/MediCal ☐Other: _____

Does this coverage include pharmacy benefits? ☐Yes ☐No Does this coverage provide any other benefit riders? ☐Yes ☐No

If Yes, please indicate which one(s): _____

Name of Covered Member:	**Member ID:**	**Date of Birth:**	**Sex:**	**Effective Date** (If different)	**Expiration Date** (if different)

The statements made above are true and correct to the best of my knowledge. I understand that federal laws [8 U.S.C. and 100] provide for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefit Advisors.

_____ Your Signature

_____ Relationship to TRICARE Sponsor

_____ Date

Please Note: Incomplete forms may result in a claims payment delay.

Mail Form to:
Humana Military Healthcare Services
P.O. Box 740061, Louisville, KY 40201-7461
(502) 580-1860 Fax

3/04

TP34-1186.5

1-800-444-5445
www.humana-military.com

Humana Military Healthcare Services, Inc.
1-800-444-5445

PGBA, LLC (PGBA) Electronic Claims
1-800-403-3950

Wisconsin Physicians Service TRICARE For Life
1-866-773-0404

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